TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
CONFIRMATIVE MANAGEMENT SVC

Respondent Name
HARTFORD FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-23-0640-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 24, 2022	G0483 and 80307	$650.00	$0.00
	Total	$650.00	$0.00

Requestor's Position

"DENIED: NON-COVERED CHARGE(S); TREATING DOCTOR AND/OR SERVICES RENDERED WERE NOT APPROVED BASED UPON HANDLER REVIEW. Dr. Gonzalez was approved to treat."

Amount in Dispute: $650.00

Respondent's Position

"The bill in question was processed on 3/23/22 under control number… and denied as not authorized per the adjuster response. Do not pay unless Pre-Cert was authorized. It is now required for all new treatment. They were notified of Pre-Cert requirements on 2-17-22."

Response Submitted by: Hartford

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code (TLC) 408.021 sets out the entitlement to medical benefits.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 96 - NON-COVERED CHARGE(S)
- NABA - REIMBURSEMENT IS BEING WITHHELD AS THE TREATING DOCTOR AND/OR SERVICES RENDERED WERE NOT APPROVED BASED UPON HANDLER REVIEW. IF YOU REQUIRE ADDITIONAL INFORMATION REGARDING THIS BILL DECISION, CONTACT THE CLAIM HANDLER.
- 309 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- AUTH - PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE·CERTIFICATION/ AUTHORIZATION. PRE-AUTHORIZATION WAS NOT OBTAINED AND TREATMENT WAS RENDERED WITHOUT THE APPROVAL OF TREATING DOCTOR. IF YOU REQUIRE ADDITIONAL INFORMATION REGARDING THIS BILL DECISION, CONTACT THE CLAIM HANDLER.

Issues

Is the respondent's denial reason supported?

Findings

The requestor seeks reimbursement for CPT/HCPCs codes 80307 and G0483 rendered on February 24, 2022. The insurance carrier denied the disputed service with denial reason codes indicated above.

Texas Labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

The requestor submitted insufficient documentation to support that the services rendered, were provided by, or recommended by the employee's treating doctor. The DWC finds that the insurance carrier's denial reason is therefore supported. As a result, reimbursement of the d disputed services, cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		January 23, 2023
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.