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
Doctors Hospital at Renaissance

Respondent Name
McAllen ISD

MFDR Tracking Number
M4-23-0649-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
November 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 12, 2022	20610	$238.80	$0.00
	Total	$238.80	$0.00

Requestor's Position

The requestor did not submit a position statement with this dispute.

Amount in Dispute: $238.80

Respondent's Position

"The allowance on this bill in dispute is correct per the OPPS fee guidelines."

Response submitted by: Dean G. Pappas, PLLC

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out the requirements of prior authorization.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – The charge exceeds the APC rate for this service
- T197 – Payment denied/reduced for absence of, or exceeded, pre-certification and/or authorization

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of an outpatient hospital service rendered in January of 2022. The insurance carrier denied the service based on lack of prior authorization.

   DWC Rule §134.600 (p)(2) states in pertinent part, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   Review of the submitted documentation found insufficient evidence to support prior authorization was obtained prior to the outpatient procedure.

   No additional payment is 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.

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

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 28, 2022 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.