



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MATTHEW FERGUSON, MD

Respondent Name

NATIONAL AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-23-2328-01

Carrier's Austin Representative

Box Number 01

DWC Date Received

May 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 24, 2022	13160	\$1,593.00	\$0.00
Total		\$1,593.00	\$0.00

Requestor's Position

"PLEASE CONSIDER REPROCESSING THIS CLAIM THAT WAS DENIED FOR NO AUTHORIZATION WITHIN THE TIME PERIOD ALLOWED. I HAVE ATTACHED NOTES SHOWING THAT THE DEPT DID TRY TO REACH OUT TO CORVEL TO OBTAIN AUTHORIZATION AND IT WAS CLOSED. PLEASE REVIEW THAT THIS IS NOT OUR MISTAKE AND DID TRY TO REACH OUT WITHIN THE PERIOD ALLOWED TO OBTAIN AUTHORIZATION."

Amount in Dispute: \$1,593.00

Respondent's Position

"The Requestor did not obtain preauthorization under rule §134.600 (listed above) and services were not deemed emergent as defined in rule §133.2(5)."

Response Submitted by: CorVel

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.600](#) sets out the preauthorization, concurrent utilization review, and Voluntary Certification of Health Care.

Denial Reasons

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

- 197 – Payment adjusted for absence of precert/preauth.
- 78 – Return to operating room. Related procedure.
- W3 – Appeal/reconsideration.

Issues

1. Is the insurance carrier's denial reason supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for surgery performed in a facility rendered on November 24, 2022.

The surgery service in dispute was denied by the workers' compensation carrier due to lack of authorization. Review of the CMS-1500 documents that the surgery service was billed with place of service "21." Place of service 21, documents that the surgery service was rendered in an in-patient facility.

28 TAC §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (1) inpatient hospital admissions, including the principal scheduled procedure(s) and length of stay..."

The DWC finds that the requestor was required to obtain preauthorization for the surgery service rendered in an inpatient facility. As a result, the requestor is entitled to \$0.00 reimbursement for date of service, November 24, 2022.

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 established that reimbursement of \$0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 14, 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 prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.