



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Austin Regional Clinic

Respondent Name

Executive Risk Indemnity

MFDR Tracking Number

M4-24-0765-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

November 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 27, 2023	26356-F7	\$2,162.00	\$0.00
June 27, 2023	26356-59-F7	\$2,162.00	\$0.00
June 27, 2023	64831-51-F7	\$1,383.00	\$0.00
Total		\$5,707.00	\$0.00

Requestor's Position

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: \$5,707.00

Respondent's Position

"Corvel Corporation is the Bill Review agent the licensed Utilization Review Agent (URA) for Chubb/ Executive Risk Indemnity. To date, there have been no requests for preauthorization of a surgical procedure for this claim/claimant. ...In their request for reconsideration (attached), the Requestor indicates the IW resent his Blue Cross insurance information; unaware the service required preauthorization. Additionally, the Requestor indicates the rendering provider determined the right middle finger required 'urgent' surgical repair."

Response submitted by: Corvel

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. [28 TAC §134.600](#) sets out prior authorization requirements.

Denial Reasons

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

- 197 – Payment adjusted for absence of precert/preauth.
- W3 – Appeal/Reconsideration.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in June of 2023. The insurance carrier denied the services as required prior authorization not obtained.

DWC Rule 28 TAC 134.600 (p)(2) states in pertinent part, "Non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section..." Based on the type of service rendered, the Division finds prior authorization was required.

While the submitted documentation does contain evidence of billing and payment by the injured workers commercial insurance, once the requestor was notified of the correct workers' compensation carrier, insufficient evidence was found to support a request for authorization was made. Because preauthorization was required and not obtained, payment is not 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 reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 21, 2023
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 electrónico CompConnection@tdi.texas.gov.