



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Hand & Wrist Center of Houston

Respondent Name

Hartford Casualty Insurance Company

MFDR Tracking Number

M4-22-2019-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 20, 2021	26357, 13160 x 2 and 11043	\$7,349.04	\$0.00
Total		\$7,349.04	\$0.00

Requester's Position

"The healthcare provider's position on this claim is that this date of services have been underpaid. We find that none of the services billed on the claim were paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code."

Amount in Dispute: \$7,349.04

Respondent's Position

"CorVel maintains the requestor, Mark Howard Henry is not entitled to reimbursement for CPT Code(s) 26357, 13160, 13160, and 11043 in the amount of \$7,349.04 for, date of service 05/20/21 based on failure to obtain preauthorization for non-emergency health care in accordance with preauthorization rules set forth under §134.600(p)(2)."

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 the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reason(s)

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment code(s):

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

Issues

1. Did the requestor obtain preauthorization for the surgical services rendered on May 20, 2021?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor, Hand & Wrist Center of Houston, submitted medical fee dispute M4-22-2019-01 to DWC for resolution pursuant to 28 TAC §133.307. The dispute concerns surgical services provided by the requestor on May 20, 2021, and billed with place of service code "22" which indicates the dispute service was rendered in an outpatient hospital setting. The insurance carrier denied the services with reason code 197 defined as "Payment adjusted for absence of precertification or preauthorization."

TAC 28 §134.600 (p)(12) states, "(p) Non-emergency health care requiring preauthorization includes...." (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section..."

The DWC finds that the insurance carrier's denial reason is supported, and as a result, reimbursement cannot be recommended.

2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307. The DWC finds that the requestor submitted insufficient documentation to support that the disputed service was preauthorized in accordance with 28 TAC §134.600. As a result, \$0.00 reimbursement 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 concludes that the insurance carrier is not liable for the disputed services.

Order

Based on the submitted information, pursuant to Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

		June 5, 2024
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, call CompConnection at 1-800-252- 7031, Option three, 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 512-804-4812.