

Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Hand & Wrist Center of Houston

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-23-2959-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 4, 2023	26442-F7, 2644251-F7, and 26442-51-58 x 2	\$10,751.24	\$0.00
Total		\$10,751.24	\$0.00

Requester's Position

"The healthcare provider's position on this claim is that this date of service has been partially denied. We find that one of the charges on this claim has not been 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. The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code"

Amount in Dispute: \$10,751.24

Respondent's Position

"Texas Mutual has no record of receiving a preauthorization or an attempt to obtain preauthorization. The facility did not obtain preauthorization for services rendered per Rule 134.600. Health care providers can refer to non-network preauthorization requirements at <https://www.texasmutual.com/providers/provider-faq#preauth>. Our position is that no payment is due."

Response Submitted by: Texas Mutual Insurance Company

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 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):

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 891 – No additional payment after reconsideration.
- W3 & 350 – In accordance with the TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 18 – Exact duplicate claim/service.
- 197 – Precertification/authorization/notification /pre-treatment absent.
- 878 – Appeal (request for reconsideration) previously processed. Refer to rule 133.250(H).
- 930 – Pre-authorization required; reimbursement denied.

Issues

1. Are the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor, Hand & Wrist Center of Houston, submitted medical fee dispute M4-23-2959-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns surgical services provided by the requestor on January 4, 2023, and denied by the insurance carrier due to lack of preauthorization.

The insurance carrier denied the disputed services due to lack of preauthorization. Rule 28 TAC §134.600 applies to the services in dispute.

28 TAC §134.600(a)(7) defines preauthorization as "a form of prospective utilization review by a payor or payor's utilization review agent of health care services proposed to be provided to an injured employee."

28 TAC 134.600(f) states in pertinent part, "(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section...". 28 TAC 134.600(p)(2) states that "Non-emergency health care requiring preauthorization includes... outpatient surgical or ambulatory surgical services". The surgical services in dispute required preauthorization if they were non-emergency services. The requestor argues in their position statement that "the injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

28 TAC §134.600 (c)(1) (A-B), states, 'The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

- (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
- (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

28 TAC §134.600 states, "(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise... (2) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care... (6) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care."

28 TAC §133.2 (5) (A-B), defines emergency, "Emergency—Either a medical or mental health emergency as follows:

- (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
 - (i) placing the patient's health or bodily functions in serious jeopardy, or
 - (ii) serious dysfunction of any body organ or part;
- (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person."

28 TAC §134.600 (p)(12) states, "Non-emergency health care requiring preauthorization includes... (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

DWC concludes that the provider failed to meet its burden of proof to establish that the dates of service in dispute were emergency care. TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue.

2. The DWC finds that the medical documentation does not document or meet the requirements

set out in 28 TAC §133.2 to override 28 TAC §134.600. As a result, the requestor was required to obtain preauthorization for the disputed services. Because preauthorization was required and not obtained, the requestor is entitled to \$0.00 for the disputed services.

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 20, 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, please 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 prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.