TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Baylor Orthopedic & Spine

Respondent Name
General Motors, LLC

MFDR Tracking Number
M4-24-0032-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 18, 2023	64718	$3,500.56	$0.00

Requester's Position

"Per EOB received bill denied due to non-covered charges. Please note that the patient received treatment relating to work comp injury, and authorization was obtained for treatment by the adjuster….which proof of authorization enclosed for review. Please reprocess and remit payment for amount due."

Amount in Dispute: $3,500.56

Respondent's Position

"On April 18, 2023, Claimant underwent a right elbow cubital tunnel release. Pursuant to Texas Administrative Code §134.600 (p) the services provided require pre-authorization through Utilization Review. However, Requestor has provided no evidence to show that the services were pre-authorized by Carrier's Utilization Review Agent; therefore, payment for the disputed date of service was properly denied."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

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. Labor Code §413.017 identifies the medical services that are presumed reasonable.
2. Texas Administrative Code (TAC) §133.307. sets out the procedures for resolving medical fee disputes.
3. 28 TAC §180.1 sets out the definitions for general rules for enforcement.
4. 28 TAC §134.60 sets out the preauthorization, concurrent utilization review, and voluntary certification of health care guidelines.
5. 28 TAC §137.100 sets out the Treatment Guidelines.
6. 28 TAC §133.240 sets out the medical bill processing of medical payment and denials by the insurance carrier.
7. Chapter 19 sets out the utilization review for health care provided under Workers' Compensation Insurance coverage.

Denial Reasons

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

- 50 - These are non-covered services because this is not deemed a medical necessity by the payer.
- N861 – Documentation does not support the services rendered were medically necessary.
- PI –These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are the reasons provided by the insurance carrier for denying the claim supported by evidence or documentation?
2. Did the requester obtain preauthorization for the services in dispute?
3. Based on the applicable rules, is the requester entitled to receive payment for the disputed service?

Findings

1. The requester seeks reimbursement for CPT Code 64718, rendered on April 18, 2023. The insurance carrier denied payment on the grounds that the service was not medically necessary and that the documentation did not support medical necessity. The division will determine whether the insurance carrier properly denied the disputed services based on lack of medical necessity.

   DWC Rule 28 TAC §137.100(e) states:
   "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Definitions found in §19.2003 clarify the following terms:

   - Retrospective utilization review (§19.2003(b)(31)) is a review of health care services already provided to an injured employee and excludes services previously reviewed prospectively or concurrently.
   - Utilization review (§19.2003(b)(33)) is a system for preauthorization and concurrent review, or retrospective review, to determine if health care proposed, ongoing, or already provided to an injured employee is medically reasonable and necessary. It excludes elective requests for coverage clarification or prepayment guarantees.
   - Utilization review agent (URA) (§19.2003(b)(34)) includes the insurance carrier, its agents, or any contracted entities providing utilization review.

   Further, 28 TAC §133.240(q) requires that when denying payment due to an adverse determination, the insurance carrier must comply with §19.2009 and, if disputing medical necessity, also comply with §19.2010. This includes providing the health care provider with a reasonable opportunity to discuss the billed services with a physician prior to issuing adverse determination.

Finally, 28 TAC §133.307(d) requires responses to medical fee dispute requests to be legible and properly submitted. When medical necessity is disputed, the insurance carrier must provide supporting documentation in accordance with §19.2005.

The division finds that the insurance carrier's denial based on medical necessity is not supported by the documentation, as outlined above.

2. This dispute concerns non-payment for a surgical procedure performed at an outpatient facility on April 18, 2023. A review of Box 63 on the UB-04 medical bill, labeled "Treatment Authorization Codes," reveals the code "EMAILAPPROVAL" provided by the requester.

   An email dated March 24, 2023, from…, Claims Examiner at Sedgwick Claims Management Services, Inc., states:
   "We are authorizing surgery with Dr. Westkaemper. Once scheduled, please provide us with the date of surgery as well as the post-operative evaluation."

   Pursuant to 28 TAC §134.600(f), the requester or injured employee must obtain preauthorization from the insurance carrier before providing or receiving health care listed in subsection (p). Additionally, concurrent utilization review must be requested before exhausting the preauthorized treatments or time period, with approval required prior to extending authorized care as specified in subsection (q).

   According to 28 TAC §180.1(4), appropriate credentials are defined as the certifications, education, training, and experience necessary to provide the requested health care. Furthermore, Texas Labor Code §408.0043 mandates that any physician conducting peer review, utilization review, or independent review must possess the same or a similar specialty as the physician who requested, ordered, or provided health care.

   In this case, prior authorization was required for the disputed surgical procedure. While a "verbal approval" was reportedly obtained from the claims examiner, the division finds that the claims examiner lacked the authority to make a determination regarding medical necessity or to authorize the procedure.

3. The division concludes that the requester failed to provide sufficient evidence of preauthorization in accordance with applicable laws and regulatory requirements. Therefore, reimbursement for these services cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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, the DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 8, 2025 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 prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.