



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-25-0496-01

Carrier's Austin Representative

Box Number 45

DWC Date Received

October 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 14, 2024	N417478082301ML	\$0.00	\$0.00
May 14, 2024	IV NS ADD-A-VIAL BAG 100M	\$0.00	\$0.00
May 14, 2024	PRE-OP INJ IV Push Initial	\$0.00	\$0.00
May 14, 2024	AN AIRWAY LMA UNIQUE SILI	\$0.00	\$0.00
May 14, 2024	DRESSING, GAUZE BULKY-S	\$0.00	\$0.00
May 13, 2024	36415	\$0.00	\$0.00
May 13, 2024	84703	\$0.00	\$0.00
May 13, 2024	80048	\$0.00	\$0.00
May 13, 2024	85027	\$0.00	\$0.00
May 13, 2024	86850	\$0.00	\$0.00
May 13, 2024	86900	\$0.00	\$0.00
May 13, 2024	86901	\$0.00	\$0.00
May 14, 2024	64704	\$3,405.08	\$0.00
May 14, 2024	ANESTHESIA GEN LEVEL-1 F1	\$0.00	\$0.00
May 14, 2024	J2405	\$0.00	\$0.00
May 14, 2024	J3010	\$0.00	\$0.00
May 14, 2024	J2001	\$0.00	\$0.00
May 14, 2024	J0171	\$0.00	\$0.00
May 14, 2024	J2704	\$0.00	\$0.00
May 14, 2024	J3301	\$0.00	\$0.00

May 14, 2024	J2250	\$0.00	\$0.00
May 14, 2024	J0690	\$0.00	\$0.00
May 14, 2024	A9270	\$0.00	\$0.00
May 14, 2024	RECOVERY ROOM EACH ADDL	\$0.00	\$0.00
Total		\$3,701.08	\$0.00

Requestor's Position

The requestor did not include a position statement but did submit a copy of their reconsideration request dated September 13, 2024 that states, "This is a formal request for reconsideration of payment for services render to the above referenced patient. Attached you will find the UB, itemized bill, first SORM rejection letter, Careworks authorization letter and medical records."

Amount in Dispute: \$3,701.08

Respondent's Position

"In a review of the charges billed it was determined that the facility did not perform or bill for the procedure codes and/or services that were preauthorized and deemed medically necessary."

Response submitted by: SORM

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 requirements of prior authorization.

Denial Reasons

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

- 197 – Payment denied/reduced for absence of precertification/preauthorization.
- W3 – Reporting purposes only.
- 193 – original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier’s denial supported?

Findings

1. The requestor is seeking reimbursement of outpatient hospital surgical services rendered in May of 2024. The insurance carrier denied the disputed service for lack of authorization. DWC Rule 28 TAC §134.600(p)(2) states in pertinent part, “Non-emergency health care requiring preauthorization includes outpatient surgical of ambulatory surgical services as defined in subsection (a) of this section.”

Based on the rule shown above prior authorization was required. Documentation included with the request for MFDR includes a “Utilization Review Recommendation WC Network Certified, Referral Number 0003-2234-4700.” The certified services included the following.

- 15005 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)
- 15004 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
- 64831 – Suture of digital nerve, hand or foot; 1 nerve.
- 64832 – Suture of digital nerve, hand or foot; each additional digital nerve.

Review of the submitted medical bill found code 64704 – Neuroplasty; nerve of hand or foot.

The insurance carrier’s denial is supported as the surgery reported and billed was not prior authorized.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

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

November 27, 2024
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.