



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Brett Nathan Robin

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-25-0939-01

**Carrier's Austin Representative**

Box Number 45

**DWC Date Received**

December 30, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 30, 2024	29825	\$2972.10	\$0.00
September 30, 2024	29826	\$854.00	\$0.00
<b>Total</b>		<b>\$3826.10</b>	<b>\$0.00</b>

### Requestor's Position

"CareWorks will not issue retro authorizations after the surgery and therefore we filed a reconsideration with the medical records as instructed in order to get the surgeries paid. Unfortunately, the result of the reconsideration is that the surgery charges were again denied for no preauthorization. ...We strive to get a preauthorization for the exact CPT codes as best as we can, but SORM should have approved our reconsideration based on all this..."

**Amount in Dispute: \$3826.10**

### Respondent's Position

The Austin carrier representative for State Office of Risk Management is State of Texas. The representative was notified of this medical fee dispute on January 7, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## **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. [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 denied the payment for the disputed services 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. Did the requestor support prior authorization was requested and received for medical services in dispute?

### Findings

1. The requestor is seeking reimbursement of physician services of an outpatient hospital surgical procedure. The insurance carrier denied the service as no authorization.

Review of the information submitted with this request for MFDR found authorization was received for code 29827, but insufficient evidence was found to support a request was made for the codes in dispute 29825 LT and 29826 LT.

DWC Rule 134.600 (p)134.600 (p)(2) states in relevant 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 above, the Division finds prior authorization was required but not obtained for the disputed codes 29825 LT and 29826 LT. No payment 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 finds the requestor has not established that additional 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

March 26, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).