



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Fort Worth ISD

MFDR Tracking Number

M4-25-1100-01

Carrier's Austin Representative

Box Number 2

DWC Date Received

January 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1, 2024	29823	\$5,939.35	\$0.00

Requestor's Position

"Per EOB received bill denied for no authorization. Please note that authorization was approved for CPT code 29823/RT... Arthroscopy under Authorization# 178032, and proof of authorization enclosed for review. We ask that you reprocess and remit payment according to TX work comp guidelines."

Amount in Dispute: \$5,939.35

Respondents' Position

"Based on the submitted documentation, payment will not be recommended. Baylor Orthopedic & Spine requested Preauthorization for a ... Arthroscopy with Extensive Debridement to be done under a different claim number than the currently documented. Baylor Orthopedic & Spine billed services under claim number ..., and not Documentation shows services were in fact rendered under a different claim number entirely."

Response Submitted by: Injury Management Organization, Inc. (IMO)

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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.600](#) sets out the preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

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

- 197 - Precertification/authorization/notification /pre-treatment absent.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 - TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

Issues

1. Is the insurance carrier's denial supported?
2. Is the requester entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of surgical services rendered on August 1, 2024, and billed under CPT code 29823. The requester is seeking reimbursement in the amount of \$5,939.35. The insurance carrier denied the disputed procedure due to lack of preauthorization.

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

A review of the pre-authorization determination letter reveals a date of injury and injured employee claim number, that differs from the date of injury and claim number presented in this medical fee dispute resolution request. According to the division records the injured employee has two injury dates and two claim number. The preauthorization determination does not pertain to the date of injury and claim number involved in this dispute. The insurance carrier denied the disputed service due to lack of preauthorization. The division finds that under 28 TAC §134.600(p), the requestor was required to obtain preauthorization for the claim number and date of injury that pertains to this dispute. Because preauthorization was required and not obtained, reimbursement cannot be recommended.

2. The DWC finds that the required preauthorization was not obtained and the carrier's decision to deny the claim is supported. As a result, the requester is not entitled to reimbursement for the disputed services.

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.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed service.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 19, 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, 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.