TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Memorial Hermann Specialty Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-25-2497-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
June 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 18, 2025	26608	$2,266.91	$0.00

Requester's Position

"Per EOB received, CPT code 26608 was not paid correctly per TX work comp fee Schedule. Please note surgical code should be reimbursed at 200% GARR."

Amount in Dispute: $2,266.91

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

Response submitted by: Gallagher Bassett

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

- 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.
- 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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 197 - 5 – Precertification/authorization/notification/pre-treatment absent.
- 45 -1 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- TX353 – This charge was reviewed according to the submitted invoice and documentation.
- TX370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- XXU00 – There was not UR procedure/treatment request received.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the rule applicable to reimbursement?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on March 18, 2025. The insurance carrier made a payment in the amount of $4,232.82 but indicated on the explanation of benefits that pre-authorization was absent and no UR procedure/treatment request was received. DWC Rule 134.600 (p)(2) states, "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services…"

   Review of the submitted documentation submitted with the MFDR request shows Review #6854692. This review is for a different individual and different procedure.

   The Division of Workers' Compensation finds precertification/authorization was required. Insufficient evidence was found to support the disputed services received the required pre-authorization/utilization review. The requirements of rule DWC Rule 28 TAC §134.600 were not met, no reimbursement 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 requester has not established that additional 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 services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 11, 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 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 electronico CompConnection@tdi.texas.gov.