



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

METHODIST DALLAS
MEDICAL CENTER

Respondent Name

SAFETY NATIONAL CASUALTY CORP.

MFDR Tracking Number

M4-25-2812-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 8, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 12, 2024	Outpatient Procedure	\$729.73	\$0.00

Requester's Position

"REQUESTING REVIEW OF AUTHORIZATION THAT SHOULD HAVE COVERED FOLLOW UP VISITS."

Amount in Dispute: \$729.73

Respondent's Position

"Our bill audit company has determined that no further payment is due... Rationale: Denial is correct as the services billed require prior authorization."

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

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 procedures for preauthorization requirements of healthcare services.

Denial Reasons

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

- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 00663 - REIMBURSEMENT HAS BEEN CALCULATED BASED ON THE STATE GUIDELINES.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 31065 - This service was not pre-authorized in conformance with TWCC Rule 134.600.
- 5283 - Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.
- 90563 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 93 – No claim level adjustment.
- P12 – Workers' Compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's denial, based on lack of preauthorization, supported?
2. Is the requester entitled to reimbursement?

Findings

1. The requestor, Methodist Dallas Medical Center, billed the insurance carrier for outpatient surgical services rendered November 12, 2024, in an ambulatory outpatient facility. A review of the submitted explanation of benefits (EOB) documents finds that the insurance carrier denied reimbursement for the outpatient surgery services based on lack of preauthorization.

DWC finds that 28 TAC §134.600 applies to the services in dispute.

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;"

DWC finds that the outpatient surgical service in dispute, provided in an outpatient facility setting, required preauthorization. The requester has the burden to prove that the date of service and procedure in dispute was preauthorized in accordance with 28 TAC §134.600 (p) for the insurance carrier to be liable for reimbursement.

A review of the submitted documentation finds no evidence that preauthorization of the disputed date of service or procedure was requested or obtained by Methodist Dallas Medical Center.

DWC finds that the denial reason of the disputed service, based on lack of preauthorization, is supported.

2. The requestor, Methodist Dallas Medical Center, is seeking reimbursement in the amount of \$729.73 for outpatient surgical services rendered on November 12, 2024.

Because the insurance carrier’s denial reason based on lack of preauthorization is supported, DWC finds that the requestor is not entitled to reimbursement.

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 that the requestor has not established that reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 14, 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 electrónico CompConnection@tdi.texas.gov.