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**
Methodist Dallas Medical Center

**Respondent Name**
Safety National Casualty Corp

**MFDR Tracking Number**
M4-25-2813-01

**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 |
|---|---|---|---|
| October 31, 2024 | Minor Procedure | $729.73 | $0.00 |

## Requester's Position

"Requesting review of authorization denial."

**Amount in Dispute:** $729.73

## 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."

**Supplemental response July 17, 2025**

"We've confirmed that the authorization denial is appropriate as we have no auth on file."

**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.
- DWC Rule 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:

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 193/90563 – 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.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requester is seeking payment of outpatient hospital services rendered on October 31, 2024. The insurance carrier denied the service for lack of required prior authorization. DWC Rule 28 TAC §134.600 (p)(2) states, "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the information submitted with this dispute found insufficient evidence to support the required prior authorization was obtained. 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 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 services.

**Authorized Signature**

| | | |
|---|---|---|
| | | September 25, 2025 |
| Signature | Medical Fee Dispute Resolution Officer | 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.