TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
LEGENT OUTPATIENT SURGERY FRISCO

Respondent Name
TEXAS MUTUAL INSURANCE

MFDR Tracking Number
M4-26-0744-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 27, 2025	27654	$4,614.44	$0.00
February 27, 2025	28120	$1,825.18	$0.00
February 27, 2025	76000-TC	$62.09	$0.00
February 27, 2025	C1713	$3,449.88	$0.00
	Total:	$9,951.59	$0.00

Requester's Position

"The originally authorized procedure 20680-Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate), authorized on Review# … , would be bundled into 27654-Repair, secondary, … tendon, with or without graft. Therefore 20680 was not billed due to the carrier following Medicare's NCCI guidelines. Since we did not erroneously bill the only CPT approved by Genex prior to DOS, we have received $0 in payment for the treatment of your claimant. Please see the attached additional medical records, all supporting the necessity of services rendered, and reconsider CPTs 27654 & 28120 as medically necessary."

Amount in dispute: $9,951.59

Respondent's Position

"This claim is in the WorkWell, TX network and the health care service(s) rendered require preauthorization per Rule 134.600. Texas Mutual can confirm the healthcare provider requested

preauthorization, however the services were partially certified. Attached is the preauthorization request submitted for CPT codes 20680, 27654, 27691, the service/CPT code that was certified was CPT code 20680, which was not included on the 1st bill submission received May 6, 2025 (see attached CMS1500). The services in dispute were not certified. Our position is that no payment is due."

Response submitted by: Texas Mutual Insurance Co.

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, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out requirements of timely medical bill submission.
3. Texas Insurance Code (TIC) Chapter §1305 governs workers' compensation health care networks.
4. 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:

- CAC-P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-197 - PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- CAC-39 - SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED.
- D25 - APPROVED NON-NETWORK PROVIDER FOR WORKWELL, TX NETWORK CLAIMANT PER RULE 1305.153 (C).
- 275 - THE HEALTH CARE PROVIDER REQUESTED PREAUTHORIZATION, HOWEVER, THE INSURANCE CARRIER DENIED APPROVAL (ACCORDING TO CHAPTER 134).
- 785 - SERVICE RENDERED IS INTEGRAL TO SERVICE REQUIRING PREAUTHORIZATION OR DOS EXCEEDS PREAUTH, ADDITIONAL PREAUTH OR EXTENSION NOT ON RECORD.
- 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN

ACCORDANCE WITH THE NETWORK CONTRACT.

- CAC-18 & 224 - EXACT DUPLICATE CLAIM/SERVICE.
- CAC-29 – TIME LIMIT FOR FILING HAS EXPIRED.
- 731 - PER 133.20(B) PROBIVER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.
- 928 - HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMELY FILING OF BILL (408.0272).

Issues

1. Are the disputed services out-of-network health care?
2. Were the disputed services preauthorized for out-of-network health care?
3. Was a corrected claim submitted timely to the insurance carrier?
4. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester, Legent Outpatient Surgery Frisco, submitted a medical fee dispute, tracking number M4-26-0744-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns outpatient surgery services provided in a licensed ambulatory surgical center (ASC) on February 27, 2025. Per the submitted documentation the injured employee's claim is within the WorkWell network. The requester is not within the WorkWell network. As a result, the requester provided out-of-network health care to the injured employee.

2. Texas Insurance Code (TIC) requires that out-of-network health care be preauthorized for the insurance carrier to be liable for the reimbursement of the out-of-network health care rendered. Texas Insurance Code §1305.103 states in pertinent part, "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I."

   Because the services in dispute are found to have been provided as out-of-network health care, DWC finds that the requester was required to obtain preauthorization unless the exceptions in TIC §1305.006 apply. TIC §1305.006 states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

   (1) emergency care;

   (2) health care provided to an injured employee who does not live within the service area

of any network established by the insurance carrier or with which the insurance carrier has a contract; and

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to §1305.103."

A review of the submitted documentation finds a utilization review document dated February 13, 2025, in which one of the disputed procedure codes, 27654, was denied preauthorization. DWC finds no evidence that the other three disputed procedure codes, 28120, 76000-TC and C1713 were requested for preauthorization.

In accordance with 28 TAC 134.600(o), the requester has 30 days from receipt of a written adverse determination to request a reconsideration of preauthorization, stating in pertinent part, "(1) The requestor or injured employee may within 30 days of receipt of a written adverse determination request the insurance carrier to reconsider the adverse determination and shall document the reconsideration request." A review of the submitted documents finds the first date of preauthorization appeal by the requester to have been on July 14, 2025, more than 30 days past the written notice of adverse determination dated February 13, 2025.

DWC finds that TIC §1305.006(1) and (2) were not shown to be applicable exceptions to the preauthorization requirement in this case.

DWC finds that the procedure codes in this dispute, 27654, 28120, 76000-TC, and C1713, were not preauthorized for out-of-network health care as required in accordance with Texas Insurance Code and DWC Rules and Statutes.

3. A review of the submitted documentation finds that the requester submitted a corrected claim including three of the procedure codes in dispute on the corrected medical bill. The corrected claim was audited by the insurance carrier on September 19, 2025. DWC finds no evidence in the submitted documentation to confirm on what date the corrected claim was submitted or received by the insurance carrier. Thus, the greater weight of evidence concludes that the corrected claim was submitted on or near September 19, 2025.

   A review of the submitted explanation of benefits (EOB) dated September 19, 2025, finds that the insurance carrier denied the corrected claim request due to untimely filing of the medical bill.

   28 TAC §133.20 which sets out requirements of timely medical bill submission, states in pertinent part "(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   A review of the submitted EOB dated September 19, 2025, finds that the medical claim in dispute was first received by the insurance carrier on or near September 19, 2025, more than 95 days after the disputed date of service. DWC finds no evidence submitted to support that the corrected claim was submitted prior to 95 days past the disputed date of service.

4. The requester is seeking reimbursement in the amount of $9,951.59 for surgical services rendered on February 27, 2025, in an ambulatory surgical center.

   Because DWC finds no evidence of preauthorization for the disputed out-of-network surgical services provided on the disputed date of service, reimbursement cannot be recommended.

   Because DWC finds no evidence that a corrected claim was submitted timely to the insurance carrier, reimbursement cannot be recommended.

   DWC finds that the requester is not entitled to reimbursement for the disputed out-of-network surgical services rendered on February 27, 2025, in an ambulatory surgical center.

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.

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 reimbursement for the disputed service in the amount of $0.00.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 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.