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

Doctors Hospital at Renaissance

Respondent Name

Hidalgo County

MFDR Tracking Number

M4-26-1302-01

Insurance Carrier's Austin Representative

BOX 21 Thornton Biechlin Segrato Reynolds & Guerra Lc

DWC Date Received

January 9, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 9, 2025	J1010	$0.00	$0.00
May 9, 2025	20550	$553.4	$0.00
	Total	$553.44	$0.00

Requester's Position

Excerpt from document dated October 9, 2025, "According to TWCC Guidelines, Rule §134.403 states the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount In Dispute: $553.44

Respondent's Position

"Corticosteroid injections, specifically in these circumstances, don not qualify as emergent care and therefore require preauthorization."

Response Submitted By: Thornton, Biechlin, Reynolds, & Guerra

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.600 sets out the requirements of prior authorization.

Adjustment Reasons

1. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
2. 197 – Precertification/authorization/notification/pre-treatment absent.
3. 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. What is DWC considering in this medical fee dispute?
2. Is prior authorization required per applicable DWC rules for the disputed services?
3. Does DWC find reimbursement is due to the requester?

Findings

1. The requester is seeking reimbursement of a steroid injection for date of service May 9, 2025 in the amount of $553.44. The code for the medication lists $0.00 as an amount in dispute. The insurance carrier denied at the time of adjudication and reconsideration for lack of required authorization.

2. 28 TAC 134.600(p) states, Non-emergency health care requiring preauthorization includes; (2) outpatient surgical or ambulatory surgical services…

   Review of the information submitted with this request for MFDR did not sufficiently support the services rendered on May 9, 2025 in this outpatient hospital setting received prior

authorization.

3. DWC finds that the insurance carrier's denial is supported, no payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections 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	February 12, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.