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 MRI & Diagnostic

Respondent Name
City of Dallas

MFDR Tracking Number
M4-23-2922-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
July 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
03/22/2023	73221	$2,756.00	$0.00
	Total	$2,756.00	$0.00

Requester's Position

""This bill was rejected due to services not authorized by network/primary care providers. I have attached the notification form providing authorization for us to treat patient. Please see attached and reconsider for payment."

Amount in Dispute: $2,756.00

Respondent's Position

""The Letter of Referral presented by the provider is in reference to the [body part] MRI. A bill was processed, and payment recommended for the [body part] MRI on 4.20.23 under check number 392360. However, the bill in question on this MDR is for CPT code 73221-LT which is for the [body part]. No referral was approved for the [body part] MRI. A copy of the Referral on file is attached for your review."

Response Submitted by: Injury Management Organization, Inc.

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 sets out the procedures for resolving medical fee disputes.

2. Texas Insurance Code (TIC) Chapter 1305 governs workers' compensation health care networks.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment code(s):

- 243 – Services not authorized by network/primary care providers.

Issues

1. Are the disputed services out-of-network health care?

2. Under what conditions is the insurance carrier liable for out-of-network health care?

3. Is the insurance carrier liable for the disputed services?

Findings

1. The requestor submitted a medical fee dispute resolution (MFDR) request, to DWC for resolution according to 28 TAC §133.307. The dispute concerns an outpatient imaging service provided by the requestor on March 22, 2023. Per the submitted documentation and from information known to the division, the injured employee's claim is within the IMO Med-Select Network. The requestor is not within the IMO Med-Select Network. As a result, the requestor provided out-of-network health care to the injured employee.

2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code statutes and Texas Administrative Code rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of TIC, Chapter 1305, are applicable to the DWC's ability to apply the TLC statutes and DWC rules for out-of-network health care. TIC §1305.153 (c) states that "Out-of-network providers who provide care as

described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

TIC §1305.006 which addresses insurance carrier liability for out-of-network health care, 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."

3. The requestor has the burden to prove that the conditions outlined in TIC §1305.006 were met for the insurance carrier to be liable for the disputed services.

   Submitted documentation provides no evidence that the treating doctor approved or recommended imaging that meets the description of CPT code 73221. The authorizing notification form that the requestor refers to in their position statement is notification that the treating doctor has ordered an MRI for a different body part other than the one described by disputed service code, CPT 73221.

   Review of submitted documentation finds that the requestor failed to provide any documentation to support that any of the conditions of TIC §1305.006 were met in this dispute. As a result, DWC finds that the insurance carrier is not liable for the out-of-network health care in dispute.

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. The Division concludes that the insurance carrier is not liable for the disputed services.

Order

Based on the submitted information, pursuant to Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		August 14, 2023
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 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 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 tres o correo electronico CompConnection@tdi.texas.gov.