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

Requestor Name
South Texas Radiology Group

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-1120-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 8, 2023	70450/26	$97.66	$0.00
	Total	$97.66	$0.00

Requestor's Position

"Our doctor performed imaging services in the ER at Medina Regional Hospital. We billed Texas Mutual as this is the information the patient provided. Texas Mutual denied no authorization. We sent a request for reconsideration & that was denied. Please help us with final adjudication of these bills for dates of service 08/08/2023."

Amount in Dispute: $97.96

Respondent's Position

"The provider asserts the treatment was a medical emergency, no additional supporting documentation has been received to support the (redacted) was work related, or that a medical emergency as defined in Rule 133.2(5)(A) was imminent. Diagnostic results from the CT scan submitted supports (redacted). ...Texas Mutual maintains its position that preauthorization was

required for CT Scan."

Response submitted by: Texas Mutual

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 requirements of prior authorization.
3. 28 TAC §133.2 defines emergency.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- CAC-W3- In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-197 – Precertification/authorization/notification absent.
- DC4 – No additional reimbursement allowed after reconsideration.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 785 – Service rendered is integral to service requiring preauthorization or DOS exceeds preauth, additional preauth or extension not on record.

Issues

1. Did the respondent raise a new issue?
2. What rule is applicable to reimbursement?

Findings

1. The respondent indicates in their position statement, "The bill received for date of service

8/08/23 was for diagnosis (redacted). Review of the claim file supports the compensable injury for the workers comp claim is (redacted), therefore preauthorization would be required for any further treatment related to his worker's comp claim."

DWC Rule 28 TAC §133.307(d)(2)(F) states in pertinent part, "The responses shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The respondent's position that states reported diagnosis was not related to compensable injury will not be considered in this review.

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

   Based on the above, prior authorization was required for the disputed service.

   The requestor states on their reconsideration dated October 18, 2023, "Emergency room visit cannot be denied for lack of authorization."

   DWC Rule 28 TAC §134.600(c)(1)(A) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when the following situations occur: an emergency as defined in Chapter 133 of this title.

   DWC Rule 28 TAC §133.2 (5)(A)(i)(ii) states, "Emergency—Either a medical or mental health emergency… a medical emergency is the sudden onset of a medical condition manifested by acute symptom of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably be expected to result in placing the patent's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part."

   Review of the submitted documentation found insufficient documentation to support the CT scan interpretation rendered in the outpatient emergency room met the definition of emergency outlined above. The insurance carrier's denial is supported. 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 requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 8, 2024 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.