Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE CO

MFDR Tracking Number
M4-12-1788-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JANUARY 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient states services which were provided were covered under worker's compensation claim."

Amount in Dispute: $613.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual received a medical dispute on 01/27/12 filed by Ernesto Blanco, MD @ South Texas Radiology Group. The charges are for professional component of procedure code(s) 72156/26, 72157/26, and 72158/26. The surgeon failed to obtain pre-authorization for the primary procedure and the hospital stay for this date was denied as not pre-authorized. The charges related to this hospital stay are not separately reimbursable."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2011	CPT Code 72156-26 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	$202.85	$0.00
	CPT Code 72157-26 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	$202.85	$0.00
	CPT Code 72158-26 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	$186.77	$0.00
	CPT Code 74020-26 Radiologic examination, abdomen; complete, including decubitus and/or erect views	$20.89	$0.00

TOTAL		$613.36	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
4. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - XE19-These services were delievered for a non-authorized surgical procedure. As the surgeon failed to obtain pre-authorization for the primary procedure, by extension all ancillary procedures (such as anesthesia) lack the requisite authorization as well and are not separately reimbursable. Preauthorization was not obtained.
   - X049-Not treating doctor.

Issues

1. Does the submitted documentation support a medical emergency?
2. Do the disputed X-ray and MRIs require preauthorization? Is the requestor entitled to reimbursement?

Findings

1. The respondent contends that the requestor is not due reimbursement for the disputed services because preauthorization was not obtained.

   The requestor states in the letter requesting reconsideration that "Emergency Room visit cannot be denied for lack of authorization (section 134.600 of TAC 28)."

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

   28 Texas Administrative Code §133.2 (3) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   A review of the submitted documentation does not support a medical emergency per 28 Texas Administrative Code §133.2 (3).

2. The respondent contends that because preauthorization was not obtained for the surgery and hospitalization than all related services are not reimbursable.

   28 Texas Administrative Code §134.600(p)(1) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." The requestor did not submit any documentation to support that preauthorization was obtained for the hospitalization and surgery, and that the related services did not require preauthorization.

   Furthermore, 28 Texas Administrative Code §134.600(p)(8)(A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   CPT codes 72156, 72157 and 72158 have a reimbursement rate of grater than $350 in the current Medical Fee Guideline.

Review of the submitted documentation finds that the requestor did not support that the disputed MRIs were the initial MRIs and did not require preauthorization. No documentation was submitted that preauthorization was obtained for the disputed services. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/20/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.