



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requester Name**

South Texas Radiology Group

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-24-0562-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

November 6, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 26, 2023	70450-26	\$97.66	\$0.00
<b>Total</b>		\$97.66	\$0.00

### Requester's Position

"We received a call from Texas Mutual adjuster Kathryn Nichols on 7/20/2023. She asked that we submit our bill for date of service 5/26/23 to Texas Mutual. We billed Texas Mutual & our bill denied for no authorization. Our request for reconsideration was also denied. Please help us with final adjudication of these bills for date of service 5/26/2023."

**Amount in Dispute:** \$97.66

### Respondent's Position

"SOUTH TEXAS RADIOLOGY GROUP submitted a bill to Texas Mutual for a CT scan performed in the emergency department. Texas Mutual reviewed the documentation and found no evidence that the treating doctor referred the injured worker to the emergency department. The injured worker had a follow up on 5/25/23 with the treating doctor and was scheduled for another follow up on 6/1/23. The... the injured worker was seeking a second opinion. The... patient has not completely resolved from his episode approximate 1 month ago, that the neurologic examination was unremarkable, and that the head CT is unremarkable. Therefore, the documentation does not support an emergency."

**Response Submitted by:** Texas Mutual Insurance Company

## 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 the procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.

### **Denial Reason(s)**

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

- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- CAC-B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
- CAC-W3& 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-40 – CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENT/URGENT CARE.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (888) 532-5246.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 242 – NOT TREATING DOCTOR APPROVED TREATMENT.
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2.

## **Issues**

1. Does the service in dispute require preauthorization?
2. Did the requestor submit documentation to support that the service in dispute was an emergency?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The requestor, South Texas Radiology Group, submitted medical fee dispute M4-24-0562-01 to DWC for resolution pursuant to 28 TAC §133.307. The dispute concerns an outpatient, emergency room diagnostic CT scan provided by the requestor on May 26, 2023.

The insurance carrier denied the service in dispute due to lack of preauthorization.

28 TAC §134.600(a)(4), defines a diagnostic study as, "Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic individuals. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis."

28 TAC §134.600 (p)(8) states, "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; or (B) without a reimbursement rate established in the current Medical Fee Guideline..."

The DWC finds that preauthorization was not required for the service in dispute.

2. The requestor submitted the dispute requesting reimbursement for the diagnostic imaging rendered in the hospital emergency room on May 26, 2023. The disputed service is governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307.

The insurance carrier denied the CT scan with denial reason "899 – Documentation and file review does not support an emergency in accordance with Rule 133.2."

28 TAC §133.2 (1)(5) (A)(i-ii), states, "(5) 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..."

The requestor has the burden to prove that the service in dispute was provided as emergency care. DWC concludes that the provider failed to meet its burden of proof to establish that the date of service in dispute was emergency care.

TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue. The position statement did not explain how the care provided on the dates of service was emergency care and was not sufficient to show that the care provided was for a medical emergency as defined in TAC §133.2. Because the treatment for this date of service was not shown to be emergency care, the insurance carrier is not liable for reimbursement.

**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 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

July 22, 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](http://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](mailto: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 prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.