TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Texas Spine and Joint Hospital

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-25-0576-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 6, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2024	CPT code 73721-LT-TC Rev. Code 610	$7,747.00	$0.00

Requestor's Position

"At the 3:32 mark, Mitchell states that he does not see that the employer uses the healthcare network; and at 4:12, states that "you should be good to go." The Hospital employee responds, "so no auth required?" Mitchell responds "right." Shortly after the call concludes. Prior to appealing this office reached out to Ms. Woodard explaining the situation; she did not respond. Because CorVel's agent/employee expressly represented that authorization would not be required for treatment CPT 73721, the Hospital's bill should not have been denied for failing to obtain preauthorization. The Hospital did all that it could to ensure preauthorization was obtained, and CorVel represented that it was not necessary before treatment."

Amount in Dispute: $7,747.00

Respondents' Position

"The Requestor is indicating "preauthorization" was obtained from a "Kay Mitchell" in the lack of response from the adjuster, Debbie Woodard. The Requestor further indicates that "Kay Mitchell" asked for time to determine if the employer… was in the Corvel Certified Texas HCN. Once it was determined that the employer was not in the HCN "Mitchell…states that 'you should be good to go'…

- There is NO 'Kay Mitchell' employed by Corvel. The Claims Assistant to Debbie Woodard is Angela Mitchell.
- Preauthorization can only be provided by a Texas-licensed UR agent. Neither an adjuster nor a claims assistant can provide preauthorization as they are not licensed UR agents under Texas rules. Corvel's UR department is the only licensed agent that is authorized to provide preauthorization.
- The Requestor goes between indicating they requested authorization from 'Mitchell' to preauthorization from 'Mitchell'. With Mitchell indicating they needed to check the employer's HCN status, this person was checking to see if authorization was needed for the facility to provide care to a possible HCN claim. The 'Hospital employee responds, so no auth required?' Mitchell responds 'right'. No auth was needed as the claim is not a TX HCN claim. As I'm sure 'Mitchell' is aware, he/she cannot provide preauthorization for services listed under rule 134.600. With the Hospital employee asking for authorization the assumption is that the Hospital was asking for Out of Network authorization.

Given the Requestor did not follow proper channels to obtain preauthorization of services as defined under 134.600, the Respondent maintains that no violation of the Workers' Compensation Act or division rules occurred. CorVel respectfully requests the division issue a decision indicating the requestor is entitled to $0.00 reimbursement for date of service 04/29/2024 in the amount of $7747.00 based on the division rules referenced herein."

Response Submitted by: CorVel

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.403 sets out the hospital facility outpatient fee guidelines.
4. 28 TAC §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 197 – Payment adjusted for absence of precert/preauth.
- Note: Repeat diagnostic studies require pre-auth.

- Note: Please be advised that CPT code 73721 was done by another provider on 10-6-2023. Preauthorization was required for DOS 4-29-24.
- W3 – Appeal/reconsideration.

Issues

1. What is the service in dispute?
2. Is preauthorization required for a repeat diagnostic study?
3. Who is authorized to perform utilization reviews for determination of medical necessity and preauthorization?
4. Is the Medical Fee Guideline reimbursement amount for CPT code 73721-TC greater than $350.00?
5. Is the requester entitled to reimbursement?

Findings

1. The dispute involves the non-payment of a diagnostic radiology study performed at an outpatient facility on April 29, 2024. The service was billed under CPT code 73721-TC, and the requestor is seeking reimbursement in the amount of $7,747.00.

2. The requestor seeks reimbursement for a repeat diagnostic radiology study. The insurance carrier denied payment on the basis that "repeat diagnostic studies require preauthorization."

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

   Additionally, 28 TAC §134.600(p)(8) states that preauthorization is required for:
   "A repeat individual diagnostic study, unless otherwise specified in this subsection, (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."

   Since CPT code 73721-TC has an established reimbursement rate, the Division must determine whether this rate exceeds $350.00 by applying 28 TAC §134.403.

3. In accordance with 28 TAC §134.600(u)(1):
   "All utilization reviews must be performed by an insurance carrier registered with, or a utilization review agent certified by, the Texas Department of Insurance under Insurance Code Chapter 4201 and Chapter 19 of this title."
   These agents or carriers must also comply with Labor Code §504.055 and all applicable provisions under Chapter 19, Subchapter U, particularly those concerning expedited medical benefits for first responders.

4. The Division applies 28 TAC §134.403 to determine the maximum allowable reimbursement (MAR). This rule mandates that reimbursement is based on the Medicare Outpatient Prospective Payment System (OPPS) methodology, as published annually by CMS.

Per Rule §134.403(f)(1), the MAR is calculated as follows:

- Multiply the Medicare facility-specific amount (which includes labor and non-labor portions) by 200%.
- The labor portion (60% of the APC payment rate) is adjusted by the facility wage index.
- The non-labor portion (40%) is added to the adjusted labor amount to obtain the Medicare facility-specific amount.

Based on this formula, the maximum allowable reimbursement for CPT code 73721-TC exceeds $350.00. Therefore, preauthorization was required for this service.

5. The Division finds that the requestor did not obtain preauthorization for the repeat diagnostic study performed on April 29, 2024. As such, reimbursement is not 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.

The DWC finds the requestor 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	June 13, 2025 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, 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.