



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

South Texas Radiology
Imaging

Respondent Name

City of San Antonio

MFDR Tracking Number

M4-25-0894-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

December 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 29, 2024	72148	\$400.08	\$383.53

Requestor's Position

"IMO denied our bill for no authorization. We sent a reconsideration request stating we received verbal approval from adjuster Danny Allen. Our reconsideration request was denied."

Amount in Dispute: \$400.08

Respondent's Position

The Austin carrier representative for City of San Antonio is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on December 24, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 \(TAC\) §134.600](#) sets out the requirements of prior authorization.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guidelines for professional medical services.

Denial Reasons

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

- 197 – Precertification/authorization/notification/pre-treatment absent.
- BT975 – No additional allowance is recommended.
- TX193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of an MRI for date of service March 29, 2024. The insurance carrier denied the disputed for lack of prior authorization. DWC Rule §134.600 (p)(8)(A) states in relevant parts, "Non-emergency health care requiring preauthorization includes: unless otherwise specified in this subsection, a repeat individual diagnostic study; with a reimbursement rate of greater than \$350 as established in the current Medical Fee Guideline..." Review of the submitted documents found no evidence to support the denied service was a repeat study. The insurance carrier did not submit a position statement to support their denial. Therefore, the services in dispute will be reviewed per applicable fee guideline.
2. DWC Rule 28 TAC 134.203 (c)(1)(2) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and

Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. ...Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

Based on the above the MAR is calculated as DWC conversion factor/Medicare conversion factor multiplied by CMS physician fee schedule allowable for location of service or $\$67.81/\$33.2875 \times \$188.27 = \383.53 .

3. The total MAR for the disputed services is \$383.53. This amount 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 requestor has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that City of San Antonio must remit to South Texas Radiology Imaging \$383.53 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 26, 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, 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 electrónico CompConnection@tdi.texas.gov.