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

**Requester Name**
Doctor's Hospital at Renaissance

**Respondent Name**
AIU Insurance

**Carrier's Austin Representative**
Box Number 19

**MFDR Tracking Number**
M4-25-2795-01

**DWC Date Received**
July 7, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| November 5, 2024 | 73721 | $453.18 | $0.00 |

## Requester's Position

The requester submitted a document titled, "Reconsideration" dated April 15, 2025 that states, "This is a formal request for reconsideration of payments for services render to above referenced patient. Please review reconsideration denial states this service was not pre-authorized. Authorization #7903342 was obtained on 10/23/2024 for CPT Code 73721 from 10/23/2024 – 01/23/2025."

**Amount in Dispute:** $453.18

## Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed."

**Response submitted by:** Gallagher Bassett

# 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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out the fee guidelines for prior authorization.

Denial Reasons

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

- 198-3 – Precertification/notification/authorization/pre-treatment exceeded.
- N54 – Claim information is inconsistent with pre-certified/authorized services.
- P12-3 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- XXU05 – The billed service exceeds the UR amount authorized.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requester is seeking reimbursement of outpatient diagnostic imaging rendered on November 5, 2024. The insurance carrier denied the service as being not authorized.

   DWC Rule 28 TAC §134.600(p)(2) states in pertinent parts, "Non-emergency health care requiring preauthorization includes: outpatient…" DWC Rule 28 TAC §134.600(p)(2)(8)(A) states, "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 information submitted was insufficient to support the disputed service was prior authorized on the date of service rendered. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the Doctor's Hospital at Renaissance has not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| _____ | _____ | September 25, 2025_ |
| Signature | Medical Fee Dispute Resolution Officer | 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.