



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEDICAL EDGE HEALTHCARE GROUP

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-11-3810-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 30, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We called and received authorization...Texas Mutual denied the claim, stating they had paid Tech Health."

Amount in Dispute: \$555.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No payment is due the requestor from Texas Mutual."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2010	MRI 73721 TC	\$555.94	\$513.79

FINDINGS AND DECISION

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

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240 sets out the requirements for medical payments and denial by insurance carriers.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional services
- Texas Mutual Insurance Company raised the following defenses during the medical billing process:
EOB dated January 25, 2011
 - Duplicate claim/service
 - Payment has been made to TechHealth for the same service
 EOB dated April 19, 2011

- Duplicate claim/service
 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - Payment has been made to TechHealth for the same services
 - No additional payment after a reconsideration of services.
5. 28 Texas Administrative Code §133.307(d)(2)(B) states that only those denial reasons presented to the requestor prior to the date the request will be considered. Any new denial reasons or defenses raised shall not be considered in the review.

Issues

1. Is the respondent's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement?

Findings

1. Texas Mutual Insurance Company (TMIC) is the workers' compensation carrier of record, and the respondent in this medical fee dispute. TMIC asserts in pertinent part that no payment is due because "Payment was made to TechHealth for the same service."

In its position to medial fee dispute resolution, TMIC further explains that " 1. TechHealth Inc...carries out imaging studies for its member clients...Texas Mutual is one of its clients...3. Texas Mutual contacted TechHealth regarding the billing from the requestor, who asserts it provided the technical portion of the imaging. TechHealth reported that (a) the requestor is in the network of imaging providers and (b) the requestor should bill TechHealth for the procedure. (See the authorization letter under Attachment for the Tech Health contact person and telephone number.)"

The division reviewed the documentation provided for the purpose of establishing whether Medical Edge Health Group or TechHealth performed the service in dispute. The documentation provided by TMIC in its response, and the documentation provided by Medical Edge Health Group both indicate that the service in dispute was provided by Medical Edge Health Group at its Meridian Diagnostic Imaging center located at 4400 Oak Park Lane, Forth Worth, TX 76109. Although TMIC provided a bill and EOB where TechHealth was listed as the "provider", the medical documentation included with the TechHealth bill denotes Medical Edge Health Group as the provider.

The division concludes the service in dispute was performed by the Medical Edge Health Group, and that Medical Edge Health Group billed Texas Mutual Insurance Company for payment. Because no documentation was found to sufficiently support that TechHealth performed the service in dispute, the carrier's denial reason is not supported.

Alternatively, if TechHealth acted as an agent of Medical Edge Health Group when it billed Texas Mutual Insurance Company, then 28 Texas Administrative Code §133.240(l) applies and requires that "Except as provided by Insurance Code §1305.153, when an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the **full amount** [emphasis added] that the insurance carrier reimburses."

For all the reasons stated, the division finds that the denial reason "Payment has been made to TechHealth for the same services" is not supported. The disputed service is therefore eligible for payment.

2. 28 Texas Administrative Code §134.203(c)(1) sets out the fee guideline for radiology which is adjusted based upon current Medicare payment policies, the current Medicare physician fee schedule allowable amount, and an annual division-established conversation factor. Medicare payment policy Revision R1171CP effective July 2, 2007 states that "Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of diagnostic imaging procedures. For the TC of diagnostic imaging services including the TC portions of the global imaging services, the payment will be capped based on the Outpatient Prospective Payment System (OPPS)."

Taking into account the OPSS payment cap, the payment for the service in dispute is calculated as follows:

$(2010\text{ DWC Conversion Factor} / 2010\text{ Medicare Conversion Factor}) \times (2010\text{ Medicare OPSS Payment Amount for 73721 TC}) = \text{Payment}$

or

$(\$54.32 / \$36.0791) \times \$341.26 = \513.79

The total allowable amount is \$513.79. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$513.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS Texas Mutual Insurance Company to remit the amount of \$513.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130 to the requestor, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Martha P Luevano
Medical Fee Dispute Resolution Manager

December 1, 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 MFDR 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 this *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.