**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## GENERAL INFORMATION

**Requestor Name and Address**

SOUTH TEXAS RADIOLOGY GROUP
PO BOX 29407
SAN ANTONIO TX 78229-5907

**Respondent Name**
Ace American Insurance Co

**Carrier's Austin Representative Box**
Box Number 15

**MFDR Tracking Number**
M4-12-2270-01

**MFDR Date Received**
March 5, 2012

## REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Patient stated services which were provided were covered under worker's compensation claim."

**Amount in Dispute:** $27.80

## RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

## SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 23, 2011 | Professional Services | $27.80 | $27.80 |

## FINDINGS AND DECISION

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

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code § 134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203(b)(1) sets out medical fee guidelines for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 165 – PAYMENT DENIED/REDUCE FOR ABSENCE OF OR EXCEEDED REFERRAL
   - 16 – Claim/service lacks information which is needed for adjudication

- 18 – Duplicate claim/service

**Issues**

1. Did the requestor comply with prior authorization requirements?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the claim as, 165 – "PAYMENT DENIED/REDUCE FOR ABSENCE OF OR EXCEEDED REFERRAL. NOT TREATING DOCTOR." Review of the submitted medical bill finds on (CMS 1500 24–B) place of Service 23 or "Emergency Room". Per 28 Texas Administrative Code §134.600, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: ...(A) an emergency, as defined in Chapter 133 of this title...). The carrier's denial is not supported. Therefore, these services will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility price or: ($8.66 x 33.9764) = $13.90 x 2 units = $27.80. The total allowable of the disputed services in review is $27.80. The carrier paid $0.00. Therefore, an additional payment of $27.80 is recommended.

**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 $27.80.

## *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 the respondent to remit to the requestor the amount of $27.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature [redacted] Medical Fee Dispute Resolution Officer February 5, 2014 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 MDR 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 the *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.**