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
South Texas Radiology

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-13-1115-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 8, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient provided Sedgwick at the time of service. We were informed by Sedgwick rep that they no longer handle this claim. She provided us with Broadspire information. Now Broadspire is denying our claim for no pre-certification."

Amount in Dispute: $16.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no written position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2012	Radiology Services	$16.52	$16.52

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 medical fee disputes.
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 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 94 – Processed in Excess of charges $0.00
   - 197 – Precertification/authorization/notification absent

Issues

1. Was the service in dispute subject to prior authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. Carrier denied the disputed service as, 197 – "Precertification/authorization/notification absent." Per 28 Texas Administrative Code §134.600(p)(8)(A) states in pertinent part, "…Non-emergency health care requiring preauthorization… includes unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline:…" Review of the submitted documentation finds the reimbursement rate is not greater than $350. The carrier's denial for no prior authorization is not supported. Therefore the disputed fee will be calculated per applicable fees and guidelines.
2. 28 Texas Administrative Code 134.203(c)(1) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." For services is 2012, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-facility price or: (54.86 / 34.0376) x $31.50 = $50.77. The total MAR for the service in dispute is $50.77. The requestor is seeking $16.52. This amount 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 $16.52.

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 $16.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.