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

BRYAN RADIOLOGY ASSOCIATES
2700 OSLER BLVD
BRYAN TX 77802

Respondent Name
TEXAS A & M UNIVERSITY SYSTEM

Carrier's Austin Representative Box
Box Number 29

MFDR Tracking Number
M4-13-1220-01

MFDR Date Received
JANUARY 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "This claim was denied for no authorization. The patient was seen in the Emergency room. This claim should have paid."

Amount in Dispute: $59.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per ODG, X-rays are not recommended in the absence of red flags. In this case, x-rays were not indicated. As documented on the Employer's First Report of Injury or illness, the injury occurred while 'moving office, lifting boxes, packed up office, furniture moving."

Response Submitted by: Starr Comprehensive Solutions, Inc., PO Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2012	CPT Code 72100-26 – X-ray exam of lower spine	$59.00	$18.87

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 §134.304 sets out the guidelines for Workers' Compensation specific services.
3. 28 Texas Administrative Code §134.302 sets out reimbursement for reimbursement of professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the treatment required preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(12), treatment/services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocol require preauthorization. The respondent in this dispute states, "Per ODG, X-rays are not recommended in the absence of red flags." The requestor billed CPT Code 71200 – X-ray exam of lower spine, using diagnosis code 756.12, Spondylolisthesis, as the first indicator. According to the ODG, CPT Code 71200-26 the bill review payment flag is yellow. Treatment with the yellow payment flag indicator "may be OK to pay up 25th percentile (or 50% depending on policy).
2. Because the ODG defines the treatment rendered to the injured workers as a yellow payment flag, the denial of preauthorization is not supported and reimbursement is due in the amount of $18.87

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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 $18.87.

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 $18.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 12, 2014
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 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).

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