



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

South Texas Radiology Imaging Center

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-15-0567-01

**Carrier's Austin Representative**

Box Number 45

**MFDR Date Received**

October 9, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We received payment from the insurance & realized we were not reimbursed according to our usual & customary amount."

**Amount in Dispute:** \$16.98

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Pursuant to Medicare payment policies, this code is not payable by Medicare per Attachment A of the CMS transmittal R2861cp. Furthermore, HCPC/CPT A9502 is a status N code which is defined as Paid under OPPS; payment is packaged into payment for other services, including outliers. The Office did not locate sufficient evidence in the requestor's dispute packet to support their statement that A9503 is payable in the amount of \$16.98."

**Response Submitted by:** State Office of Risk Management

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2014	A9503	\$16.98	\$16.98

#### 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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
  - 18 – Exact duplicate claim/service

**Issues**

1. Did the requestor support disputed services are separately payable?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Labor Code §134.203(d) states in pertinent part, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies," Review of the submitted bill finds;
  - a. Submitted code A9503 is classified as "Other/DME Purchase"
  - b. No published Medicare rate for submitted code
  - c. Place of service found on submitted bill is "11" Office. The OPPS status indicator is not applicable

Therefore, the services in dispute will be calculated per Rule 134.203(d)(2) or published Texas Medicaid fee schedule x 125%.

2. The published Medicaid fee schedule is \$16.58 x 125% = \$20.72. The requestor is seeking \$16.98. 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 \$16.98.

**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 \$16.98 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	February 24, 2015 Date
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**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.**