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
South Texas Radiology

Respondent Name
TASB Risk MGMT Fund

MFDR Tracking Number
M4-16-3527-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed 2 procedures for date of service 10/23/2012. We were reimbursed for CPT 78315 but CPT A9503 denied. We are reimbursed as usual & customary for this code."

Amount in Dispute: $16.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TASBRMF timely responded and maintained the denial on our reconsideration response due to the fact that HCPCS code A9503 is global; Medicare does not have an allowable amount for this code as it not payable separately."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2016	A9503	$16.98	$16.98

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

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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment is included in the allowance for another service/procedure
   - 193 – Original payment decision is being maintained
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Is the carrier's position statement supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states, "Medicare does not have an allowable amount for this code as it not payable separately." While no fee schedule amount is found 28 Texas Administrative Code §134.203(a)(7) states, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program." The Division finds the provisions of Rule 134.203(d)(3) is applicable and provides for reimbursement. Therefore, the carrier's position is not supported.

2. Review of the submitted medical claim finds the code in dispute is classified as Medical and Surgical Supplies - (A4206-A9999) specifically A9503 which is defined as "Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries." 28 Texas Administrative Code 134.203(d)(3) which states,

   > 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, for HCPCS; or
   > >
   > > (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   Review of the applicable DMEPOS fee schedule finds no fee schedule amount for A9503. Review of the Texas Medicaid fee schedule finds an allowable of $21.87. Pursuant to the above the maximum allowable reimbursement is calculated as follows: $21.87 x 125% = $26.09.

3. The maximum allowable for the service in dispute is $26.09. 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 on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in 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

		August , 2016
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, 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 MFDR 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.