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 GROUP

**Respondent Name**
TWIN CITY FIRE INSURANCE COMPANY

**MFDR Tracking Number**
M4-19-0579-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
October 2, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "...our claim and request for reconsideration are being denied based on Lack of Authorization... We would like to get final adjudication on the claim."

**Amount in Dispute:** $80.75

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Our investigation shows the following: 03/20/18: PLN11 filed denying claim in its entirety. Enclosed please find supportive documentation for your review."

**Response Submitted by:** The Hartford

## *SUMMARY OF DISPUTED SERVICE(S)*

| Date(s) of Service | Disputed Service(s) | Amount in Dispute | Amount Due |
|---|---|---|---|
| March 20, 2018 | 72131-26 | $80.75 | $80.75 |

## *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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

## Issue(s)

1. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Was the requestor required to obtain preauthorization for the disputed service?
3. Is the requestor entitled to reimbursement?

## Findings

1. The requestor seeks reimbursement for CPT Code 72131-26 rendered on March 20, 2018. The insurance carrier in the position summary states in pertinent part, "Our investigation shows the following: 03/20/18: PLN11 filed denying claim in its entirety. Enclosed please find supportive documentation for your review."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a position summary containing a new denial reason. To determine whether a compensability dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code § 133.240 (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service(s) was related to a compensable injury.

   Per 31 TexReg 3544, 3558 (April 28, 2006), those provisions, in pertinent part specified: Former 133.240 (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee." No documentation was found to support that the insurance carrier sent the required report (EOB) containing an explanation of the reason(s) presented to MFDR for the reduction or denial of payment. The Division concludes that the respondent has not met the requirements of 408.027. This new defense reason is therefore not supported for date(s) of service March 20, 2018. The disputed service is reviewed per applicable Division rules and fee guidelines.

2. The carrier denied the disputed service with denial reduction code "197 – Payment denied/reduced for absence of precertification/authorization." Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (8) 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; or (B) without a reimbursement rate established in the current Medical Fee Guideline. The Division finds that disputed CPT Code 72131-26, does not require preauthorization. As a result, reimbursement is calculated pursuant to 28 Texas Administrative Code §134.203.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

Procedure code 72131-26 rendered on March 20, 2018 has a MAR of $81.33. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $80.75, therefore this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to a reimbursement in the amount of $80.75.

## 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 $80.75.

## *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 $80.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

| | | |
|---|---|---|
| | | April 5, 2019 |
| 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 llamar a 512-804-4812**.