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 IMAGING CENTER

Respondent Name
JUDSON ISD

MFDR Tracking Number
M4-19-2693-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
January 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I asked for the adjuster's assistance getting this paid & she said to submit a corrected diagnosis appeal, which I did but claim still remains denied. We would like to receive final adjudication on this claim."

Amount in Dispute: $192.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 23, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY

Dates of Service	Disputed Service	Amount in Dispute	Dismissal
August 7, 2018	76700	$192.93	$192.93

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 §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §133.240 sets out the Medical Payments and Denials.
4. 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
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 167 – This (these) diagnosis (es) is (are) not covered

Issue(s)

1. Did the insurance carrier submit documentation to support the denial reason indicated on the EOBs?
2. What is the fee guideline reimbursement for CPT Code 76700?
3. Is the requestor entitled to reimbursement?

Findings

1. The service in dispute was denied by the workers' compensation carrier with denial reduction code "167 – This (these) diagnosis (es) is (are) not covered." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

   28 Texas Administrative Code §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   To determine whether such an extent-of-injury or related 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/were not related to the compensable injury.

   Review of the documentation finds that the carrier did not provided documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H). The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the division finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is ripe for adjudication of a medical fee under 28 Texas Administrative Code §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement for a radiology service rendered on August 7, 2018. 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 76700, rendered on, August 7, 2018, has a Work RVU of 0.81 multiplied by the Work GPCI of 1 is 0.81. The practice expense RVU of 2.63 multiplied by the PE GPCI of 0.938 is 2.46694. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.796 is 0.0398. The sum is 3.31674 multiplied by the DWC conversion factor of $58.31 for a MAR of $193.40. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $192.93. Therefore, this amount is recommended.

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $192.93.

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 $192.93.

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 $192.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 25, 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 de llamar a 512-804-4812.