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 CENTERS

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-19-3213-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
FEBRUARY 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have mailed & faxed our claim several times since 06/22/2018. We have not received a response to our claim submissions. We should like TDI assistance. We would like to receive final adjudication on this claim."

Amount in Dispute: $93.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The third party claim has settled on 01-08-2018 and Liberty Mutual has a dollar-for-dollar holiday on future workers compensation benefits owed. If a medical bill is received for date of service after 01-08-2018, or we are required to issue an indemnity payment; do not pay. We are not required to pay future benefits until the employee can prove that net recovery of $1,000.00 from the third party settlement is fully exhausted."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2018	CPT Code 72220	$44.11	$0.00
	CPT Code 72170	$49.58	$0.00
TOTAL		$93.69	$0.00

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 effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §417.002, effective September 1, 1993 outlines the process for recovery in third-party settlements.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.
   - 5791-The injured employee is paying medical benefits under requirements of DWC Advisory 2004-02. Pricing by the carrier will be according to the medical policies and fee guidelines established by the commission. The insurance carrier has submitted the medical bill and explanation of benefits to the injured employee for prompt payment of the adjusted amount in accordance with DWC Advisory 2004-02. Health care providers must continue to submit requests for preauthorization and to submit their medical bills to the insurance carrier as required by Commission rules.
   - P12-Workers compensation jurisdictional fee schedule adjustment.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied payment for CPT codes 72220 and 72170 based upon DWC Advisory 2004-02 - Third Party Litigation (Subrogation) Claim Processing.

Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states,

> (a) The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division reviewed the submitted documentation and finds:

- No documentation was submitted to refute the carrier's position that the services in dispute are subject to payment from a third-party settlement; and
- No documentation was found to support that the net amount recovered in the settlement was exhausted, and that the insurance carrier was required to pay benefits.

The Division concludes that the requestor has failed to support that the disputed services are eligible for reimbursement. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00. The Division emphasized that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/21/2019
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.