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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Texas Radiology

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-19-3385-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received partial payment for CPT code 73218. We mailed a request for reconsideration as we were not reimbursed per Texas Workers Comp fee schedule."

Amount in Dispute: $12.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation the bill was calculated and processed correctly per the Fee Schedule. No additional payment is due."

Response Submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2018	73218	$12.21	$12.21

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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. What rule is applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the disputes service based on the workers' compensation jurisdictional fee schedule. The applicable DWC Rule is found at 134.203 (c) (1) which states in pertinent part,

   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 (date of service yearly conversion factor).

   The Medicare Physician schedule for the location of San Antonio (Rest of Texas) finds an allowable of $363.35. The DWC conversion factor 58.31 / Medicare conversion factor 35.9996 x $363.35 = $572.34.

2. The allowable for the service in dispute is $572.34. The insurance carrier paid $462.94. The requestor is seeking $12.21. 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 $12.21.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $12.21, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		March 27, 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 Rule §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 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. **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.