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 IMAGINING CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-3908-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received payment for CPT code 73718. We mailed a request for reconsideration as we were not reimbursed per Texas Workers Comp fee schedule. We received a denied EOB in response to our request for reconsideration."

Amount in Dispute: $16.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above-mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $462.48... In this case, the OPPS fee for code 73718 is $462.48 which is less than the standard fee of $479.98. Therefore, the lesser fee of $462.48 is correct."

Response Submitted by: ESIS

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
October 4, 2018	73718	$16.71	$16.71

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, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 1 – Charge exceeds Fee Schedule allowance

Issue(s)

1. Is the insurance carrier's denial/reduction code supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement in the amount of $16.71 for CPT Code 73718 rendered on October 4, 2018. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs)..."

   CPT Code 7371 8 is defined as "MRI LOWER EXTREMITY W/O DYE." Review of the submitted documentation finds that the insurance carrier issued a payment in the amount of $462.48 and denied the remaining charges with denial reduction code "P12 – Workers compensation jurisdictional fee schedule adjustment" and "1 – Charge exceeds Fee Schedule allowance." The Division will review the disputed charge and determine whether the requestor is entitled to additional reimbursement.

2. 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... 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 73718, rendered on October 4, 2018, has a Work RVU of 1.35 multiplied by the Work GPCI of 1 is 1.35. The practice expense RVU of 7.26 multiplied by the PE GPCI of 0.938 is 6.80988. The malpractice RVU of 0.09 multiplied by the malpractice GPCI of 0.796 is 0.07164. The sum is 8.23152 multiplied by the DWC conversion factor of $58.31 for a MAR of $479.98. The insurance carrier paid $462.48, the requestor is therefore entitled to an additional reimbursement amount of $17.50. The lesser of is $16.71 therefore this amount is recommended.

3. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement amount of $16.71.

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 $16.71.

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 $16.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 22, 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 (20)** 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.