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
SOUTHWEST IMAGING CENTER

Respondent Name
CITY PUBLIC SERVICE BOARD OF SA, TX

MFDR Tracking Number
M4-19-4466-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We called Broadspire & we were informed code Q9967 remans denied for timely filing."

Amount in Dispute: $12.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been disputed due to an extent of injury dispute. We are attaching the EOB that disputes the bill."

Response Submitted by: Broadspire

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 5, 2018	Q9967	$12.00	$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 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:
   - 224 – Duplicate charge
   - 18 – Exact duplicate claim/service
   - W3 & 350 – Bill has been identified as a request for reconsideration or appeal

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. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS Code Q9967, rendered on September 5, 2018. The insurance carrier's denial reason of "D53 – Extent of injury not finally adjudication" was raised on an EOB dated June 19, 2019/June 20, 2019. The MDR dispute was received on June 11, 2019.

   Per 28 Texas Administrative Code §133.307(d)(2)(F) states that "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."

   This new defense reason is therefore not supported for date of service September 5, 2018. The disputed service is therefore reviewed per the applicable Division rules and fee guidelines.

2. 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); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The CMS processing manual indicates that HCPCs Code Q9967 contains a CCI edit, "E- Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment regulations. No RVUs are show, and no payment may be made under the fee schedule for these codes..."

   The division finds that the requestor is therefore not entitled to reimbursement for the disputed service. As a result, $0.00 is recommended.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for HCPCS Code Q9967. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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

Signature	Medical Fee Dispute Resolution Officer	August 30, 2019 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