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

Respondent Name
XL Insurance America

MFDR Tracking Number
M4-19-5240-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The fifth CPT was denied based on Medicare Multiple Procedure Rule. The payment was not reduced but denied all together."

Amount in Dispute: $69.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2019	70430 -26	$69.88	$52.41

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 services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline
   - 118 – The following radiology code has been reduced per the Medicare multiple procedure rule for diagnostic family imaging
   - 59 – Processed based on multiple or concurrent procedure rules
   - P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

The Austin carrier representative for XL Insurance America Inc is Flahive, Ogden and Latson who acknowledged receipt of the copy of this medical fee dispute on August 27, 2019.

28 Texas Administrative Code §133.307 states, 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, the division may base its decision on the available information.

Review of the documentation finds that no response has been received to date. the division will base its decision on the information available.

1. The requestor is seeking $69.88 for Code 70450 -26 for date of service March 22, 2019. The insurance carrier reduced disputed services based on multiple procedure rules and workers compensation fee schedule. But, the explanation of benefits provided indicates no payment.

   The fee amount will be calculated based on the applicable rule of 28 TAC 134.203 (c) which requires system participants to apply the Medicare payment policies with minimal modifications. The fee is calculated by dividing the DWC conversion factor by the Medicare conversion factor then multiplying this amount by the Medicare Physician Fee Schedule amount or (59.19 / 36.0391) or 1.64 x $42.55 = $69.88.

2. Review of the 2019 Diagnostic Imaging Service Subject to the Multiple Procedure payment reduction for PC and TC services CY 2019 at www.cms.gov, found code 70450 is subject to this reduction. The allowed amount will be reduced by 25% for a final allowable of $52.41. 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 $52.41.

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 $52.41, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		October 17, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.