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
Federal Insurance

MFDR Tracking Number
M4-20-0687-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…CPT code A9579 remains denied as bundled."

Amount in Dispute: $30.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel determined final action was rendered correctly for date of service 02/06/2019 based on CMS statutory exclusion and payment inclusive to another service occurring on the same day."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2019	A9579	$30.26	$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 sets out reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P14 – Payment is included in another svc/procedure same day

Issues

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

Findings

1. The requestor is seeking reimbursement of Code A9579 for date of service February 6, 2019. The insurance denied the service based on bundling.

   28 TAC §134.203 (b) Texas workers' compensation system participants shall apply the following Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers

   The applicable Medicare payment policy for this code finds it has a status code of "X" which is statutorily excluded.

   The insurance carrier's denial is supported. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 10, 2020 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.