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
MEDICAL EQUATION

Respondent Name
INCLINE CASUALTY CO

MFDR Tracking Number
M4-20-2519-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 17, 2020

REQUESTOR'S POSITION SUMMARY

"The carrier has denied partial payment on examination services provided, which are all per their request."

Amount in Dispute: $151.89

RESPONDENT'S POSITION SUMMARY

"After reviewing the bill, we have determined that the correct allowance has been paid per the fee guidelines and no additional allowance is being recommended."

Response Submitted by: Salus Claims Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2019	73110-WP-LT	$57.35	$0.00
August 13, 2019	73030-WP-RT	$38.32	$0.00
August 13, 2019	73562-WP-LT	$56.22	$0.00
	Total	$151.89	$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 (DWC).

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 fee guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- Notes: “Charges have been processed correctly. TDI/DWC states reimbursement is based on the procedure codes (CPT) codes billed. Xrays were reimbursed at the CMS Medicare Physician Fee Schedule based upon place of service 11, zip code … and multiplied by the appropriate TDI/DWCC conversion factor. We are not required to pay xrays at full billed charges. No additional allowance is due.”
- W3 – Additional payment made on appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1003 – In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received, our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.
- 6000 – Based on the receipt of additional information and/or clarfication, we are recommending further payment be made for the above noted procedure codes(s).

Issues

Is Medical Equation entitled to additional reimbursement for the services in question?

Findings

Medical Equation is seeking additional reimbursement for review of x-rays as part of a required medical examination.

Reimbursement for the services in question are based on Medicare policies using the conversion factor determined by the DWC for the appropriate year.[1] The conversion factor for 2019 is $59.19.[2]

The maximum allowable reimbursement for procedure code 73030 is $47.68. The maximum allowable reimbursement for procedure code 73110 is $57.65. The maximum allowable reimbursement for procedure code 73562 is $58.78.

Therefore, the maximum allowable reimbursement for the services in question is $164.11. Per explanation of benefits dated January 30, 2020, the insurance carrier reimbursed this amount. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 24, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.203(b) and (c)

[2] https://www.tdi.texas.gov/wc/fee/conversionfactors.html#conv

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 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.