



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

South Texas Radiology Group

Respondent Name

Employers General Insurance

MFDR Tracking Number

M4-22-0528-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

November 15, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 2, 2021	CPT Code A9575 200 units	\$34.00	\$0.00
Total		\$34.00	\$0.00

Requestor's Position

"We were paid for the procedure codes & the drug code was denied as part of the procedure codes."

Amount in Dispute: \$34.00

Respondent's Position

"CorVel determined final action was rendered correctly for date of service 02/02/21 based on CMS statutory exclusion and payment inclusive to another service occurring on the same date. Per Medicare, HCPCS code A9579 has a fee schedule status code of 'X' which indicates a statutory exclusion. These codes represent an item or service that is not in the statutory definition of 'physician services' for fee schedule payment under any circumstances. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule."

Response Submitted by: Corvel

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 97-Charge Included in another Charge or Service.
- R38-Included in another billed procedure.
- W3-Appeal/Reconsideration.

Issues

1. Is Employers General Insurance's denial based on the charge being included in the charge of another service supported?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$34.00 for CPT code A9575 rendered on February 2, 2021.

The respondent denied reimbursement for the services based upon the charge is included in the charge of another service.

On the disputed date of service the requestor billed CPT Codes 72158, 72157, and A9575.

The fee guidelines for professional services are found in 28 TAC §134.203.

Per CMS fee guideline, code A9575 is a statutory exclusion code. Statutory exclusion codes are defined as "These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule." As a result, reimbursement is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

12/15/2021

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.