TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
South Texas Radiology Group

Respondent Name
Tx Assoc of Counties Rmp

MFDR Tracking Number
M4-22-1502-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
March 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 17, 2021	71046	$42.00	$0.00
	Total	$42.00	$0.00

Requestor's Position

"We billed Texas Assoc of counties as this in the information we received. Our bill was returned y Sedgwick several times until denying for timely filing. Our request for reconsideration with proof of timely filing was denied."

Amount in Dispute: $42.00

Respondent's Position

As reflected in the Explanation of Bill Review processed on March 9, 2022, upon reconsideration TAC RMP paid South Texas Radiology Group pursuant to the applicable fee guidelines ($18.49).

Response submitted by: Burns Anderson Jury & Brenner

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for radiology services.

Denial Reasons

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

- 6514 – Timely filing denial reconsidered
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 298 – The recommended allowance is based on the value for the professional component of the service performed
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of radiology services rendered in August 2021. The insurance carrier provided evidence of payment in the amount of $18.49 via electronic funds transfer on March 10, 2022.

   The applicable fee guideline is found in §134.203(c)(1) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Radiology when performed in an office setting, the established conversion factor to be applied is (current year) conversion factor. For Surgery when performed in a facility setting, the established conversion factor of the current year.

   Review of the submitted medical bill found the place of service to be "22" or on campus outpatient hospital. The Physician Fee Schedule listed Code 71046 – 26 with an allowable of $10.55. The formula for calculating the maximum allowable reimbursement is physician fee schedule allowable multiplied by DWC conversion factor/ CMS conversion factor = MAR or $10.55 x 61.17/34.8931 = $18.49. The insurance carrier paid $18.49. No additional payment is

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 additional reimbursement is due.

Order

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

Authorized Signature

		May 2, 2022
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 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 electronico CompConnection@tdi.texas.gov.