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
Everest National Insurance Co

MFDR Tracking Number
M4-23-1429-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 28, 2022	73502	$25.08	$20.06
	Total	$25.08	$20.06

Requestor's Position

"We billed 3 charges to Gallagher Bassett. All 3 charges were different CPT codes (73610/26 72100/26 73502/26). We received payment for 2 of the charges & CPT 73502 denied as a duplicate. We mailed an appeal & our request for reconsideration was denied."

Amount in Dispute: $25.08

Respondent's Position

The Austin carrier representative for Everest National Ins Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on February 22, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

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 §133.07 sets out the guidelines of medical fee dispute resolution.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

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

- 18 – Exact duplicate claim/service

Issues

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

Findings

1. The requestor is seeking reimbursement of $25.08 for a radiology service rendered in May of 2022. The insurance carrier denied the disputed service as a duplicate.

   Review of the submitted documentation found insufficient evidence to support this service was previously paid or denied. The service in dispute will be reviewed per applicable fee guideline.

2. DWC Rule 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 …Radiology." The MAR calculation is DWC/Medicare Conversion Factor x physician fee schedule for location = MAR.

   - The DWC conversion factor for Radiology for 2022 is $62.46.
   - The Medicare conversion factor for 2022 is $33.59.
   - The CMS Carrier Code is 04412
   - The CMS Locality is 99 – Rest of Texas.
   - The CMS physician fee schedule allowable is $10.79.

- 62.46/34.6062 x $10.79 = $20.06

3. The total MAR for the disputed service is $20.06. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Everest National Insurance Co must remit to South Texas Radiology Group $20.06 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 19, 2023
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.