



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

South Texas Radiology
Imaging

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-23-2997-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
12-12-2022	73718	\$440.34	\$422.23

Requester's Position

"TASB denied our claim for no authorization. We sent an appeal to say we spoke to adjuster & we were given verbal approval for initial enhanced imaging. Our reconsideration request was denied. Please help us with final adjudication of this bill for date of service 12/12/2022. Thank you"

Amount in Dispute: \$440.34

Respondent's Position

"This request will be standing on the previous allowance of \$0.00, and no additional allowance is recommended for CPT 73718-LT as this was denied per Utilization Review... Please see the attached reconsideration EOR and DWC-60."

Response Submitted by: TASB Risk Management Fund

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.600](#) sets out the procedures for preauthorization requirements of healthcare services.
3. [28 TAC §134.203](#) sets out the fee guidelines for professional medical services.

Denial Reasons

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

- U02 – THE BILLED SERVICE WAS REVIEWED BY UR AND DENIED.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- P13 - PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES, USE ONLY IF NO OTHER CODE IS APPLICABLE.
- W3 - IN ACCORDANCE WITH TDI -DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is the insurance carrier's denial, based on utilization review, supported?
2. Is South Texas Radiology Imaging entitled to reimbursement?

Findings

1. Submitted documentation shows, the insurance carrier denied imaging service, CPT code 73718 rendered by requester, South Texas Radiology Imaging, on December 12, 2022, based on utilization review.

When responding to a medical fee dispute, 28 TAC §133.307 (d)(2)(I), which sets out the respondent's required documentation to support a denial for lack of medical necessity, states in pertinent part, "On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: ... (I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that

supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review)."

Review of documentation submitted by both parties finds that the insurance carrier provided no evidence to support the claim that it performed a utilization review in accordance with 28 TAC §133.307 (d)(2)(l).

The DWC finds that the denial reason based on utilization review is not supported. The requestor is therefore entitled to reimbursement for the disputed service.

2. South Texas Radiology Imaging is seeking reimbursement for imaging service, CPT code 73718-LT, rendered on date of service December 12, 2022. Because the insurance carrier's denial based on utilization review is not supported, the requestor is entitled to reimbursement.

CPT code 73718 is defined as magnetic resonance imaging, lower extremity other than joint; without contrast materials.

The division finds that 28 TAC §134.203 applies to the reimbursement of CPT Code 73718.

28 TAC §134.203 states in pertinent part, "(c) To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

Dates of service were rendered in 2022:

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the service was rendered in zip code 78258; therefore, the Medicare locality is 99, "Rest of Texas."
- The Medicare Participating amount for CPT code 73718 at this locality is \$233.94.
- Using the above formula, the division finds the MAR is \$422.23.
- The respondent paid \$0.00.
- The requestor is due \$422.23 for CPT code 73718 rendered on December 12, 2022.

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.

The division finds the requester has established that reimbursement in the amount of \$422.23 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the division has determined the requester is entitled to reimbursement for the disputed services.

It is ordered that TASB Risk Management Fund must remit to South Texas Radiology Imaging \$422.23 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 30, 2023

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.