Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
TPS JOINT SELF INS FUNDS

MFDR Tracking Number
M4-12-1792-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
JANUARY 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient stated services which were provided were covered under worker's compensation claim."

Amount in Dispute: $13.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2011	CPT Code 71010-26 Chest X-ray	$13.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 191-At the Adjustor's request no allowance was made.
   - 197-Precertification/authorization/notification absent.
   - 18-Duplicate claim/service.

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

The insurance carrier denied reimbursement for the disputed chest x-ray based upon "197-Precertification/authorization/notification absent."

On the disputed date of service the requestor billed CPT code 71010-26 for the diagnosis "780.2-Syncope and Collapse."

- CPT code 71010 is defined as "Radiologic examination, chest; single view, frontal."
- Modifier "26-Professional Component."

28 Texas Administrative Code §134.600(p)(8)(A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline." Review of the submitted documentation finds no evidence that the chest x-ray was a repeat study and had a reimbursement rate greater than $350.

28 Texas Administrative Code §134.600(p)(12) states "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

According to the Official Disability Guidelines (ODG), a chest x-ray is not recommended treatment for diagnosis 780.2; therefore, the disputed chest x-ray required preauthorization.

There is no evidence submitted, that the requestor obtained preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(12). As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/20/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.