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 and Address

SOUTH TEXAS RADIOLOGY GRP
PO BOX 29407
SAN ANTONIO TX 78229-0407

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-2267-01

MFDR Date Received
May 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are asking TDI to review this situation and determine whether or not the insurance carrier is liable for this claim."

Amount in Dispute: $15.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As this is emergency room treatment and multiple body areas have now been accepted as compensable, we have reprocessed the charges to allow payment…"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2012	Professional Medical Services	$15.21	$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 medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the requirements for submission of medical documentation.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – DUPLICATE CLAIM/SERVICE
   - U301 – THIS ITEM HAS BEEN REVIEWED ON A PREVIOUSLY SUBMITTED BILL OR IS CURRENTLY IN PROCESS.

Issues

1. Did the requestor support number of services billed?

Findings

1. The Carrier denied the disputed service for date of service May 9, 2012, code 73030, (1) unit of service "Radiologic examination, shoulder; complete; minimum of 2 views" which includes minimum number of views or more views when needed to adequately complete the study " as 18 – "DUPLICATE CLAIM/SERVICE 28". Texas Labor Code §133.210 states in pertinent part "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents." Review of the medical documentation finds;
    a. "ATTACHMENT G"; Exam: Shoulder 2 Views or More, Left;
    b. Date: 05/09/2012 5:22 PM.

   Only one record supporting one unit of service performed was found. Carrier's denial as duplicate charge is supported. No additional payment can be 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

		Februaru 5, 2014
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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