



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARK H. HENRY, MD

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-15-4252-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

AUGUST 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the CCI edits included in The Orthopaedics – Upper: Spine and Above Coding Companion the x-ray (procedure code 73140) is not inclusive to procedure code (26756)."

Amount in Dispute: \$71.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The xray on 2/18/15 that was billed along with the surgery was actually denied as a duplicate because payment was issued on a separate bill. The xray was also billed with the initial evaluation and payment was issued. There is no documentation of a second xray. A copy of the bill and eob that include the xray are included."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 18, 2015, CPT Code 73140-26 Radiologic examination, finger(s), minimum of 2 views, \$71.58, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P303-This service was reviewed in accordance with your contract.U301-This item has been reviewed on a

previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.
- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The respondent states in the position summary that, "The xray was also billed with the initial evaluation and payment was issued. There is no documentation of a second xray." In support of the position, a copy of an explanation of benefits that supports payment of \$44.31 was issued for code 73140-RT. A review of the submitted dispute packet finds that the requestor billed code 73140-26 and 26756 on one bill and 73140-RT and 99203-25 on another bill for the disputed date of service. The requestor did not submit any documentation to support that a second x-ray was performed , to support billing code 73140-26.

To determine if the requestor is due any additional payment for code 73140-RT, the Division refers to 28 Texas Administrative Code §134.203(c).

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the 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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

The 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.7547.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77004, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

The Medicare Participating Amount is \$33.90.

Using the above formula, the Division finds the MAR for code 73140-26 is \$11.38.

The MAR for code 73140-RT is \$49.23. The respondent paid \$49.23 minus contractual reduction. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		12/09/2015
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, 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 MFDR 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.