



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

SOUTH TEXAS RADIOLOGY GROUP

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-16-2009-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed 3 Chest X-Rays performed by 3 different Radiologists. The 3rd claim has been denied based on duplicate service. We mailed a request for reconsideration with medical reports attached to show this was not a duplicate service. Our request for reconsideration was denied. We would like to receive final adjudication on this claim."

Amount in Dispute: \$14.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning charges for a chest x-ray on August 10, 2015. Requestor billed \$31.00 under CPT 71010-26-77. Carrier denied that reimbursement was owed as this was a duplicate of other billed services on that date."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2015	CPT Code 71010-26-77 Radiologic examination, chest; single view, frontal	\$14.20	\$14.20

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, effective March 1, 2008, sets the reimbursement guidelines for professional services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 18-Exact duplicate claim/service.

Issues

Does the documentation support billing code 71010-26-77? Is the requestor entitled to reimbursement?

Findings

The insurance carrier denied reimbursement for the disputed X-Ray based upon reason code "18-Exact duplicate claim/service".

The requestor contends that reimbursement is due because "We billed 3 Chest X-Rays performed by 3 different Radiologists." In support of the position, the requestor submitted a copy of a report that indicates the claimant underwent chest x-rays at 05:09, 10:46 and 11:35. In addition, the requestor appended modifier "77- Repeat Procedure by Another Physician or Other Qualified Health Care Professional." The Division finds that the requestor has supported that disputed chest x-ray was not a duplicate and reimbursement is recommended.

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 78201, which is located in San Antonio, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

The Medicare Participating Amount is \$9.08.

Using the above formula, the Division finds the MAR is \$14.27 or lesser amount. The requestor is seeking \$14.20. The respondent paid \$0.00. As a result, reimbursement of \$14.20 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$14.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$14.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

04/07/2016

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.