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
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-16-3312-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed two chest x-rays performed by 2 different providers. We were reimbursed for 1st chest X-ray . . . The second chest x-ray was denied . . . we should be reimbursed for the second chest x-ray."

Amount in Dispute: $14.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines"

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2016	Diagnostic Radiological Services, Professional Component, procedure code 71010-26	$14.35	$14.35

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 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not bee received/adjudicated.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the disputed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards diagnostic radiological services billed by doctor Pablo Pallan under procedure code 71010 (chest X-ray, frontal view) with modifier 26 (professional component –interpretation and report). A similar service was billed for the same date (February 18, 2016) by doctor Paul Bertolino—who works for the same radiology group—using the same code with the addition of modifier 77 (repeat procedure performed by another physician). Doctor Bertolini's charge was paid. Doctor Pallan's charge, which is the subject of this dispute, was not paid.

   The insurance carrier denied payment for Doctor Pallan's services with claim adjustment reason code B15 – "This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated."

   28 Texas Administrative Code §133.307(d)(2) requires the respondent to provide any missing information not provided by the requestor and known to the respondent—including copies of any missing EOBs, medical bills or medical records pertinent to the dispute. It further requires the respondent to submit a position statement of reasons why the disputed medical fees should not be paid; including a discussion of how the Labor Code, division rules and fee guidelines impact the disputed fee issues, as well as how the submitted documentation supports the respondent's position for each disputed fee issue. §133.307(d)(1) provides that If the division does not receive such information within 14 calendar days of the dispute notification, then the division may base its decision on the available information. This decision is based on the information available at the time of review.

   The respondent's position statement did not explain the above denial reason or provide information as to what other qualifying service or procedure was required that had not been received or adjudicated. The respondent did not present documentation to support or justify this denial reason. Based on the preponderance of evidence presented for review, the insurance carrier's denial reason is not supported. Accordingly, this service will be reviewed for payment according to applicable Division rules and fee guidelines.

2. This dispute regards professional medical services with reimbursement subject 28 Texas Administrative Code §134.203(c), which requires that:

   > To determine the MAR [Maximum Allowable Reimbursement] 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 Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2016 is $56.82.

   For procedure code 7101026, service date February 18, 2016, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.18. The practice expense (PE) RVU of 0.07 multiplied by the PE GPCI of 0.92 is 0.0644. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.25262 is multiplied by the Division conversion factor of $56.82 for a MAR of $14.35.

3. The total allowable reimbursement for the services in dispute is $14.35. The insurance carrier has paid $0.00. The amount due to the requestor is $14.35.

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 $14.35.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $14.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	July 22, 2016
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.