



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

CITY OF SAN ANTONIO

MFDR Tracking Number

M4-20-0886-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

DECEMBER 10, 2019

REQUESTOR'S POSITION SUMMARY

"Please process the claim according to the Texas Workers Compensation Guidelines."

Amount in Dispute: \$8.33

RESPONDENT'S POSITION SUMMARY

"The amount paid was processed correctly per the Texas Fee Schedule. No additional amount is being recommended."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2019	CPT Code 72133	\$8.33	\$8.33

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 (DWC).

Background

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - W3-Reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

Is the requestor entitled to additional reimbursement for CPT code 72133?

Findings

The fee guidelines for professional services are found in 28 TAC §134.203.

Per 28 TAC §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.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2019 DWC conversion factor for this service is 59.19.

The Medicare Conversion Factor is 36.0391.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78229, which is located in San Antonio, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

Using the above formula, the DWC finds the MAR is:

CPT Codes	Medicare Participating Amount for Professional Component	MAR	Carrier Paid	Total Amount Due
72133	\$257.94	\$423.64	\$415.31	\$8.33

The difference between the MAR and amount paid is \$8.33; this amount is recommended in reimbursement.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$8.33.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$8.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		01/07/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.