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
ORTHOTEXAS PHYSICIANS & SURGEONS

Respondent Name
TECHNOLOGY INSURANCE CO

MFDR Tracking Number
M4-20-2615-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
JUNE 30, 2020

REQUESTOR'S POSITION SUMMARY

"See the attached dictation that supports the services rendered. Please process this claim for payment immediately."

Amount in Dispute: $74.00

RESPONDENT'S POSITION SUMMARY

"Copies of the x-rays images were provided, but they were not high-quality images and were difficult to see. Therefore, the medical bill was denied for lack of documentation."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2020	CPT Code 73030-RT Radiologic examination, shoulder; complete, minimum of 2 views	$74.00	$53.38
	CPT Code 99080-73 Work Status Report	$0.00	$0.00
TOTAL		$74.00	$53.38

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

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.

3. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-The charge was reimbursed in accordance to the Texas medical fee guideline.
   - 16-Claim/service lacks information or has submission billing error(s).
   - 205-This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 375-This is a re-evaluation bill. Billed radiology service 73030 was denied correctly as there were no views documented. Re-submitted bill and medical document reviewed and found to be insufficient. Hence, no additional payment is made. For the billed Radiology code 73030 required views are 2 but, in the submitted medical document number of views are not documented, hence denied.

Issues

Is the requestor entitled to reimbursement for CPT code 73030?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $74.00 for CPT code 73030 rendered on February 10, 2020.
2. The respondent denied reimbursement for the services based upon a lack of documentation.
3. The requestor submitted documentation to support billing CPT code 73030; therefore, the respondent's denial is not supported, and reimbursement is due.
4. The fee guidelines for professional services are found in 28 TAC §134.203.
5. 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 2020 DWC Conversion Factor is 60.32

The 2020 Medicare Conversion Factor is 36.0896

Review of Box 32 on the CMS-1500 finds the services were rendered in Plano, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

The Medicare Participating amount for CPT code 73030 at this locality is $31.94.

Using the above formula, the DWC finds the MAR is $53.38. The respondent paid $0.00. As a result, reimbursement of $53.38 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $53.38.

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 $53.38 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/24/2020
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.