



# 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 COMPANY

**MFDR Tracking Number**

M4-21-0276-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

October 14, 2020

**Response Submitted by:**

Flahive, Ogden & Latson

#### **REQUESTOR'S POSITION SUMMARY**

"We billed 5 X-Rays for date of service 02/20/2020. We received payment for four of the five procedures. The fifth CPT continues to deny as a duplicate. We filed a request for reconsideration which was also denied. Please help us with final adjudication."

#### **RESPONDENT'S POSITION SUMMARY**

"The CPT code in question is 73070 which is based upon an x-ray of the right [REDACTED]. One of the June 17, 2020 EOBs recommended reimbursement of x-rays to claimant's [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. The second June 17, 2020 EOB denied reimbursement of the right [REDACTED] on the basis that it was a duplicate of other services performed on the same day. In other words, one or more of the other x-rays included the right [REDACTED] area. Accordingly, the provider was not entitled to additional reimbursement for an additional x-ray that was already included among one or more of the other x-rays. The carrier's second EOB dated July 28, 2020 also denied the bill.

It remains the carrier's position that the provider is not entitled to additional reimbursement. The provider has already been reimbursed \$55.70."

#### **SUMMARY OF DISPUTED SERVICE(S)**

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
February 20, 2020	73070-26	\$13.24	\$13.24

#### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §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 §133.305 sets out the procedure for Medical Fee Dispute Resolution.
- 28 TAC §133.308 sets out the procedure for Medical Necessity Disputes.
- 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.

5. 28 TAC §134.204 sets out the fee guidelines for the workers' compensation specific services.
6. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 00086 – DUPLICATE CLAIM/SERVICE.
  - 18 – DUPLICATE CLAIM/SERVICE.
  - 306 – BILLING IS A DUPLICATE OF OTHER SERVICES PERFORMED ON SAME DAY.
  - 00950 – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS REFLECT ANY CHANGES
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

### **Issue(s)**

1. What is the service in dispute?
2. Did the requestor meet the billing requirements outline in 28 TAC 134.203(b)?
3. What is the rule that apply to reimbursement of radiology services?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. The requestor seeks reimbursement for CPT Code 73070-RT-26-76 rendered on February 20, 2020. The insurance carrier denied/reduced the disputed service(s) with denial reduction code(s), "18."

The insurance carrier states in pertinent part, "...one or more of the other x-rays included the right [REDACTED] area. Accordingly, the provider was not entitled to additional reimbursement for an additional x-ray that was already included among one or more of the other x-rays."

The requestor states, "We received payment for four of the five procedures. The fifth CPT continues to deny as a duplicate."

2. 28 TAC §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The DWC completed NCCI edits to identify potential edit conflicts that could possibly affect reimbursement. The following was identified:

The requestor billed the following CPT Codes on February 20, 2020. The following CPT Codes are defined as:

- 73110-26-RT – Radiologic examination, wrist; complete, minimum of 3 views
- 73060-26-RT – Radiologic examination; humerus, minimum of 2 views
- 73090-26-RT – Radiologic examination; forearm, 2 views
- 73070-26-76-RT – Radiologic examination, elbow; 2 views
- 73020-26-RT – Radiologic examination, shoulder; 1 view

The following modifiers were appended:

- Modifier 26 – Professional Component
- Modifier 76 – Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
- Modifier RT – Right Side

"Per Compliance Edit, this charge line did not trigger edits and is considered clean."

No documentation was submitted to support that this was a duplicate charge and or previously paid by the insurance carrier. As a result, the DWC finds that the insurance carriers denial reason is not supported, and the requestor is entitled to reimbursement pursuant to 28 TAC 134.203 (c).

3. 28 TAC §134.203 states in pertinent part, “(c) 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 formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

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

- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78229 which is located in San Antonio, Texas; therefore, the Medicare locality is “Rest of Texas.”
- The Medicare participating amount for CPT code 73070 at this locality is \$8.42.
- The DWC conversion factor for 2020 is 60.32.
- The Medicare conversion factor for 2020 is 36.0896.

The respondent paid \$0.00. The difference between MAR and amount paid is \$14.07. Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount. The MAR is \$14.07, the requestor seeks \$13.24, therefore this amount is recommended.

4. Review of the submitted documentation finds that the requestor is due \$13.24.

**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 \$13.24.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC 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 \$13.24 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	November 17, 2020 Date
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***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §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 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**