TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
SOUTH TEXAS RADIOLOGY GROUP

**Respondent Name**
ACE AMERICAN INSURANCE COMPANY

**MFDR Tracking Number**
M4-22-0447-01

**Carrier's Austin Representative**
Box Number 15

**DWC Date Received**
November 2, 2021

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 19, 2021 | 73560-26-LT | $14.02 | $14.02 |
| | **Total** | $14.02 | $14.02 |

## Requestor's Position

"We received payment for 2 of the charges & CPT 73560 denied as a duplicate. We mailed an appeal & our request for reconsideration was denied. We called Gallagher Bassett & the rep we spoke to, agreed the bill was denied in error. The rep sent the denied bill back for review & it was denied again."

**Amount in Dispute:** $14.02

## Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment. Supplemental response will be provided once the bill auditing company has finalized their review. Attached is a copy of all bills received to date, and their corresponding EOB's and payment details."

**Response Submitted by:** Gallagher Bassett

# Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 00086 & 18 - EXACT DUPLICATE CLAIM/SERVICE.
- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL-RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SBMIT A COPY OF THIS EOR OR CLEAR NOTATION.
- 306 - BILLING IS A DUPUCATE OF OTHER SERVICES PERFORMED ON THE SAME DAY.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement for CPT Code 73560-26-LT rendered on February 19, 2021. The insurance carrier denied/reduced the services in dispute with reduction codes indicated above.

   Review of the submitted documents finds that the insurance carrier's denial reasons presented on the EOB are not supported. As a result, the Requestor is entitled to reimbursement.

2. The guidelines for the disputed services are found at 28 TAC §134.203.

   28 TAC 134.203 (b)(1) states, "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."

   Review of the CMS-1500 documents that the requestor billed CPT Code 73560-26-LT on February 19, 2021. CPT Code 73560 is defined as "Radiologic examination, knee; 1 or 2 views.

   The requestor applied modifier 26-Professional Component to this code.

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… (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..."

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

   - The 2021 DWC Conversion Factor is 61.17
   - The 2021 Medicare Conversion Factor is 34.8931
   - Per the medical bills, the services were rendered in zip code 78233; therefore, the Medicare locality is "Rest of Texas."
   - The Medicare Participating amount for CPT code 73560-26 at this locality is $8.12.
   - Using the above formula, the DWC finds the MAR is $14.23.
   - The respondent paid $0.00.
   - 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.
   - The requestor seeks $14.02, as a result the requestor is entitled to $14.02.

4. The DWC finds that the requestor is therefore entitled to reimbursement in the amount of $14.02. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $14.02 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $14.02 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | May 12, 2022 |
| 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.