



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

MEMORIAL MRI & DIAGNOSTIC

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-15-1144-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

DECEMBER 12, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Attached are the claim and medical report/s."

**Amount in Dispute:** \$2,625.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The Requestor billed \$2,625.00 for an MRI to the left shoulder. The carrier denied payment as an injury to the left shoulder has not been accepted as part of the compensable injury. I have attached the PLN-11 form dated 04/03/14 denying a left shoulder injury as part of the [REDACTED] compensable injury."

**Response Submitted By:** AIG

**SUMMARY OF FINDINGS**

<b>Dates of Service</b>	<b>Disputed Services</b>	<b>Amount in Dispute</b>	<b>Amount Due</b>
March 10, 2014	CPT Code 73221-LT Left Shoulder MRI	\$2,625.00	\$402.23

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 Texas Register 364, sets the reimbursement guidelines for the disputed service.
- 28 Texas Administrative Code §133.240, effective July 1, 2012 sets out the procedure for medical bill processing.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
  - F630-Referring provider license number is missing or invalid. Please resubmit bill with this information included.

- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
- 18-Duplicate claim/service.
- U301-This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).

### Issues

1. Does a compensability/extent of injury issue exist in this dispute?
2. Does the documentation support billed services? Is the requestor entitled to additional reimbursement?

### Findings

1. The respondent asserts that reimbursement is not due for the disputed MRI because "The carrier denied payment as an injury to the left shoulder has not been accepted as part of the compensable injury."  
 28 Texas Administrative Code §133.240(e)(1), (e)(2)(C), and (j)(1) address the actions that the insurance carrier is required to take during the medical billing process, when the insurance carrier determines that the medical service is not related to the compensable injury.  
 A review of the submitted explanation of benefits does not support that the respondent denied reimbursement for the disputed MRI based upon not related to the compensable injury in accordance with 28 Texas Administrative Code §133.240; therefore, the Division finds that a compensability issue does not exist in this dispute.
2. According to the submitted explanation of benefits, the respondent denied reimbursement for the left shoulder MRI based upon reason code "16."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 73221 is defined as "Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)."

A review of the submitted reports supports billed service; therefore, the respondent's denial based upon reason code "16" is not supported. As a result, reimbursement is recommended.

Per 28 Texas Administrative Code §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 2014 DWC conversion factor for this service is 55.75

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77084, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

The Medicare participating amount is \$258.46.

Using the above formula, the Division finds the MAR is \$402.23. The respondent paid \$0.00. As a result, the requestor is due reimbursement of \$402.23.

**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 \$402.23.

**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 Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$402.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

  
Signature

Elizabeth Pickle, RHIA  
Medical Fee Dispute Resolution Officer

05/14/2015  
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, effective May 31, 2012, *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 MDR 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.**