



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

SOUTHWEST XRAY LP

Respondent Name

PUBLIC WC PROGRAM

MFDR Tracking Number

M4-15-3968-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the DWC060 request.

Amount in Dispute: \$225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions maintains its position that the MRI to the lumbar required preauthorization in accordance with rule 134.600 (p)(12); which states treatments/services that exceeded or are not addressed by the Commissioner's adopted treatment guidelines or protocols require preauthorization... The services exceed ODG and therefore required preauthorization."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 23, 2015	72148-26	\$225.00	\$115.37

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 §134.600 requires preauthorization for non-emergency health care.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization
 - 197 – Treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
 - W3 – Additional reimbursement made on reconsideration
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. What denial reason(s) or defenses did the insurance carrier raise during the medical bill review process?
2. Does the disputed service require preauthorization per ODG guidelines?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 72148-26 rendered on March 23, 2015. The insurance carrier reduced/denied the disputed charge with denial reason(s) code(s), "197 – Payment denied/reduced for absence of precertification/authorization and 197 – Treatment is outside of or exceeds the ODG, therefore, preauthorization is required.

2. 28 Texas Administrative Code §134.600(p)(12) "Non-emergency health care requiring preauthorization includes: treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

28 Texas Administrative Code § 137.100(f) states "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

The requestor billed CPT Code 72148-26 with diagnosis 724.4 – Thoracic or lumbosacral neuritis or radiculitis unspecified.

According to the Low Back – Lumbar & Thoracic (Acute & Chronic) Chapter of the Official Disability Guidelines (ODG), MRIs (magnetic resonance imaging) is recommended; therefore, the disputed MRI does not require preauthorization. As a result, the disputed charge is reviewed pursuant to the applicable rules and guidelines.

3. 28 Texas Administrative Code §134.203 states, "(b) 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 72148 with modifier -26. Modifier -26 is added to a CPT Code to designate that the professional component or interpretation was rendered. As a result, reimbursement is determined for the professional component only.

28 Texas Administrative Code §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 requestor seeks reimbursement in the amount of \$225.00. The MAR reimbursement for CPT Code 72148-26 is \$115.37, therefore this amount is recommended.

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 \$115.37.

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 \$115.37 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 3, 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.