



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

THE CLINIC OF NORTH TEXAS

Respondent Name

CITY OF WICHITA FALLS

MFDR Tracking Number

M4-16-2080-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did receive a precertification on 10/30/2015 from Augustina Rivas. Authorization code: 090141666. I have included all documentation that we have to support this."

Amount in Dispute: \$1,502.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case, this MRI was performed 5 days after the date of injury. The claimant did not have at least 1 month conservative therapy nor did he have severe or progressive neurologic deficit. As such, the indications for imaging were not met as outlined in ODG. The services exceed the 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
November 2, 2015	CPT Code 72148 Lumbar Spine MRI	\$1,502.00	\$329.45

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 197-Payment denied/reduced for absence of precertification/authorization.
- 197-The 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.
- W3/193-Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.
- 197-Per rule 134.600(p)(12), treatments/services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or .

Issues

1. Did the disputed MRI require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 72148 based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "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."

The requestor billed CPT code 72148 for the diagnosis M54.16 – Radiculopathy, lumbar region.

According to the Low Back Chapter of the Official Disability Guidelines (ODG), a MRI is recommended for patients with low back pain and radiculopathy. The test may be performed until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. A review of the October 28, 2015 report finds that the requestor's impression after evaluation of claimant was "pt with + SLR weakness and radicular symptoms. Needs MRI"; therefore, the disputed MRI did not require preauthorization. As a result, a preauthorization issue does not exist and reimbursement is recommended.

2. 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."

The 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.7547.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76302, which is located in Wichita Falls, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

The Medicare Participating Amount is \$209.60.

Using the above formula, the Division finds the MAR is \$329.45. The respondent paid \$0.00. As a result, reimbursement of \$329.45 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$329.45.

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 \$329.45 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		04/07/2016
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, 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.