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
MEMORIAL MRI & DIAGNOSTIC

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-1877-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A call was placed to adjuster on 08/11/2017 and we received a verbal approval … ODG indicates that MRI does not require a prior authorization based on the diagnosis. This bill was denied in error."

Amount in Dispute: $2,625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 16, 2017	Diagnostic Imaging – MRI	$2,625.00	$340.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged February 14, 2018. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – PRECERTIFICATION/ AUTHORIZATION/NOTIFICATION ABSENT."

   Rule §134.600(c)(1) requires that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in Rule §134.600(p) only in the case of an emergency as defined in Chapter 133 or preauthorization of any health care listed in subsection (p) approved prior to providing the health care.

   The disputed health care involves diagnostic imaging services. Review of division Rule §134.600(p) finds that initial magnetic resonance imaging services or diagnostic studies are not listed as requiring preauthorization. Nor was any information presented to support that this service exceeds the commissioner's adopted treatment guidelines or protocols as set out in the Official Disability Guidelines - Treatment in Workers' Comp (ODG), published by Work Loss Data Institute.

   The division thus concludes the insurance carrier's denial reason is not supported.

   The disputed services will therefore be reviewed for payment in accordance with applicable division rules and fee guidelines.

2. This dispute regards payment of magnetic imaging with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (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) . . . 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. . . .

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2017 is $57.50.

   Reimbursement is calculated as follows:

   - Procedure code 72141 has a relative value (RVU) for work of 1.48 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.48. The practice expense (PE) RVU of 4.76 multiplied by the PE GPCI of 0.913 is 4.34588. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.897 is 0.0897. The total sum of 5.91558 is multiplied by the division conversion factor of $57.50 for a MAR of $340.15.

3. The total allowable reimbursement for the services in dispute is $340.15. The insurance carrier has paid $0. The amount due to the requestor is $340.15.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $340.15.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $340.15, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 27, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.