Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-18-5098-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "She was seen at Methodist Hospital Emergency Room Department. Now our claim and request for reconsideration are being denied based on Lack of Authorization."

Amount in Dispute: $119.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge was denied as not being pre-authorized. The provider has not provided evidence that it obtained pre-authorization and thus Carrier maintains its dispute."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2018	CPT Code 72148-26	$119.70	$119.70

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, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.2, effective March 30, 2014, defines a medical emergency.
3. 28 Texas Administrative Code §134.600, effective March 30, 2014requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
5. The services in dispute were reduced/denied by the respondent with the following reason 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. Does the disputed lumbar MRI require preauthorization?
2. Is the requestor entitled to reimbursement for CPT code 72148-26 rendered on April 7, 2018?

Findings

1. According to the submitted explanation of benefits and respondent's position summary, CPT code 72148-26 rendered on April 7, 2018 was denied reimbursement based upon a lack of preauthorization.

   The requestor claims reimbursement is due because "She was seen at Methodist Hospital Emergency Room Department. Now our claim and request for reconsideration are being denied based on Lack of Authorization."

   The division considered the following statute in this decision:

   - 28 Texas Administrative Code §134.600(c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."
   - 28 Texas Administrative Code §133.2 (5) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."
   - 28 Texas Administrative Code §134.600(p)(8) requires preauthorization for "unless otherwise specified in this subsection, a repeat individual diagnostic study."
   - 28 Texas Administrative Code §134.600(a)(4) states, "(4) Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic individuals. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis."
   - 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."

   Based upon the above referenced statute and submitted documentation, the division finds the following:
   - The respondent denied reimbursement for CPT code 72148-26 based upon a lack of preauthorization.
   - The claimant sustained a compensable lumbar spine injury on [redacted].
   - CPT code 72148 is defined as "Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material." The requestor appended modifier "26-Professional component" to code 72148.
   - The requestor noted that "She was seen at Methodist Hospital Emergency Room Department."
   - He also noted that this test was compared to a previous test performed on February 12, 2018.
   - Per 28 Texas Administrative Code §134.600(p)(8) preauthorization is required for non-emergency repeat MRIs.
   - The requestor wrote the indications for the MRI were "Bowel incontinence, worsening headache, dizziness."
   - The division finds these indications support the disputed MRI was performed for a medical emergency per 28 Texas Administrative Code §133.2 (5); therefore, preauthorization was not required.
   - The division finds the requestor is due reimbursement for CPT code 72148-26.

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."

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

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78229, which is located in San Antonio, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The 2018 DWC conversion factor for this service is 58.31.

The 2018 Medicare Conversion Factor is 35.9996

The Medicare participating amount for 72148-26 at this location is $74.43.

Using the above formula the division finds the MAR is $120.56 or less. The requestor is seeking a lesser amount of $119.70. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $119.70.

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 $119.70.

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 $119.70 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	09/20/2018 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.