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
City of Beaumont

MFDR Tracking Number
M4-20-0147-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
September 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None.

Amount in Dispute: $5,902.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 20, 2019	Professional medical services	$5,902.00	$214.64

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 reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 5045 – Service(s) are denied based on provider timely filing requirement

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services for several reasons the first being lack of preauthorization. Review of the submitted documentation found at the time of reconsideration on June 12, 2019 the requestor indicates an authorization number of #122195. The insurance carrier processed this request on June 28, 2019 not maintaining the denial for lack of authorization but denied this time based on timely filing.

   Based on our review, DWC finds neither of the insurance carrier's denial are supported. The explanation of benefits dated April 15, 2019 indicates the insurance carrier received the original claim on April 9, 2019 which is within 95 days of the date of service February 20, 2019 as required by 28 TAC 133.20(b).

   The rendered services will be reviewed the applicable DWC rule and fee guideline found in 28 TAC §134.203.

2. Professional medical services are subject to provisions of 28 TAC §134.203 (b) which requires for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply 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 submitted medical bills is as follows:

Submitted Code	Does Medicare Payment Policy allow payment	Physician fee schedule amount	MAR 28 §TAC 134.203 (c)	Billed amount
72240	Yes	$107.32	59.19/36.0391 x $107.32 = $176.26	$2,010.00
77003	No, CCI edit with code 77240		N/A	$900.00
62284	No, CCI edit with code 72240		N/A	$1,412.00
99211	Yes	$23.37	59.19/36.0391 x $23.37 = $38.38	$140.00
99499	No, should not be billed on same day of minor procedure		N/A	$420.00
A4550	No, always bundled		N/A	$200.00
J3490	Excluded from Physician Fee Schedule			$710.00
Q9967	Excluded from Physician Fee Schedule			$110.00
		Total	$214.64	$5,902.00

28 TAC 134.203 (c) shows the formula to calculate the DWC fee guideline by dividing the applicable Medicare Conversion factor for the date of service by the DWC Conversion factor and then multiplying this amount by the Medicare Physician Fee Schedule amount to find the Maximum Allowable Reimbursement.

The Medicare CCI edits found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index, does not allow payment for codes 62284, 77003 and 99499.

Regarding Codes J3490 and Q9967. 28 TAC 134.203 (h) states when there is no contract the reimbursement is either the MAR amount, the health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or fair and reasonable amount consistent with the standards of §134.1 of this title.

Insufficient evidence was found to support a contract and review of the applicable Medicare and Medicaid fee schedules found no allowable. Per the above rule 28 TAC §134.1 applies.

28 TAC §134.1 states fair and reasonable must be supported by evidence that supports similar procedures provided in similar circumstances receive similar reimbursement; and be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

No documentation to support the requested amounts as required by rule was found. No additional reimbursement is recommended.

3. The allowed amount is $214.64. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $214.64.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $214.64, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 15, 2020
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.