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
BREEZE MRI
KRISTIN COLEMAN

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2135-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MAY 4, 2020

REQUESTOR'S POSITION SUMMARY

The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $666.94

RESPONDENT'S POSITION SUMMARY

"Audit staff reviewed the documentation on appeal and denied the appeal for inaccurate coding which is appropriate. According to the CPT coding guidelines there is amore appropriate cpt code for a CT Lumbar Spine w/out contrast. The provider billed cpt code 74178 which is CT of the abdomen and Pelvis, documentation submitted does not support the abdomen and pelvis."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2019	CPT Code 74178	$666.94	$0.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20, effective January 29, 2009, sets out the healthcare providers billing procedures for medical bill submission.
3. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 714-Accurate CPT/HCPCS, date of service, units, days supply, modifiers are essential for reimbursement. Submit correction w/i 95 days from DOS.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration

Issues

Does the documentation support billing CPT code 74178? Is the requestor due reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $66.94 for CPT code 74178 rendered on October 29, 2019.
2. The respondent denied reimbursement for CPT code 74178 based upon "CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," and "714-Accurate CPT/HCPCS, date of service, units, days supply, modifiers are essential for reimbursement. Submit correction w/i 95 days from DOS."
3. The fee guidelines for disputed services are found in 28 TAC §134.203.

   28 TAC §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."

   28 TAC § 133.20(c) requires "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

   CPT code 74718 is described as "Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions."

   The requestor submitted a report that indicates the exam was "CT of the lumbar spine without intravenous contrast."

   The DWC finds the submitted medical report does not support billing code 74718; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		05/29/2020
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.