



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

KRISTIN COLEMAN MD

Respondent Name

OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number

M4-20-2136-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

May 4, 2020

Response Submitted by:

No response submitted

REQUESTOR'S POSITION SUMMARY

"Work Comp Treatment/Services incorrect reduction."

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Old Republic Insurance Company is White Espey PLLC. White Espey PLLC was notified of this medical fee dispute on May 5, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d) (1).

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
December 4, 2019	72141, 72146 and 73221-LT	\$244.23	\$68.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 59 – Processed based on multiple or concurrent procedure rules
 - MP26 –IN accordance with the MS physician fee schedule guidelines, this service was reduced due to the Radiology Diagnostic Imaging Multiple Procedure rule
 - P300 – The amount paid reflects a fee schedule reduction
 - Z710 –The charge for this procedure exceeds the fee schedule allowance

Issue(s)

1. Does the MPPR apply to the disputed radiology services?
2. What are the NCCI edits for the disputed radiology services?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 72141, 72146 and 73221, radiology services rendered on December 4, 2019. The insurance carrier denied/reduced the disputed service(s) with denial reduction code(s), "MP26 –IN accordance with the MS physician fee schedule guidelines, this service was reduced due to the Radiology Diagnostic Imaging Multiple Procedure rule."

28 TAC §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) 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."

The CMS Manual System, Pub 100-200 One-Time Notification, Transmittal 1104 dated August 2, 2012 states in pertinent part,

Policy: The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. The MPPR on certain diagnostic imaging services applies to PC and TC services. It applies to both PC-only services, TC-only services, and to the PC and TC of global services. Full payment is made for each PC and TC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

Currently, the MPPR applies only when an individual physician furnishes multiple services to the same patient, in the same session, on the same day. CMS is expanding the MPPR on the PC and TC of imaging services by applying it to physicians in the same group practice (same Group National Provider Identifier (NPI)) who furnish multiple services to the same patient, in the same session, on the same day.

2. The DWC completed NCCI edits to identify if the disputed CPT Codes, 72141, 72146 and 73221 are subject to the MPPR. The DWC finds the following:

This procedure code 72146 and procedure code 72141 indicate that multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies for this line.

This procedure code 73221 and procedure code 72146 indicate that multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies for this line.

As a result, CPT Codes 72146 and 73221 are subject to the 25% reduction of the professional component.

3. 28 TAC §134.203 states in pertinent part, "(c) 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..."

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

The 2019 DWC conversion factor for this service is 59.19.

The Medicare Conversion Factor is 36.0391.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77063, which is in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston."

Using the above formula and the MPPR for radiology, the Division finds the MAR for CPT Code 72141 is \$372.83.

Using the above formula and the MPPR for radiology, the Division finds the MAR for CPT Code 72146 is \$341.60.

Using the above formula and the MPPR for radiology, the Division finds the MAR for CPT Code 73221 is \$364.61.

The DWC finds that the requestor is entitled to a total MAR of \$1,079.04. The insurance carrier issued a payment in the amount of \$1,010.85, therefore, the requestor is entitled to an additional payment in the amount of \$68.19. This amount is recommended.

- 4. Review of the submitted documentation finds that requestor is entitled to an additional payment in the amount of \$68.19.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$68.19.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$68.19 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 26, 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 TAC §133.307, 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 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 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 TAC §141.1(d).

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