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
WEST TEXAS IMAGING CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-21-1659-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 18, 2021

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"CALLED TX MUTUAL REGARDING DOS'S 9.30.20 AND 1.15.21. PER AUTOMATED RECORDING DOS 9.30.20 DENIED AS OF NOV 2020. REQUESTED FAXED COPY OF DENIAL FOR REVIEW. NO CLAIM WAS FOUND FO R DOS 1.15.21 AS IT IS SET FOR BILLING BUT NOT GONE YET. REQUESTED THIS CLAIM BE PRINTED SO THAT IT CAN BE FAXED TO CLAIMS DEPT. ALONG WITH REPORTS ATTACHED. PENDING COPY OF FAX DENIAL FOR DOS 9.30.20."

RESPONDENT'S POSITION SUMMARY

"The following is the carrier's statement with respect to this dispute for date of service 9/30/2020 to 9/30/2020. The requester billed $1,155.00; Texas Mutual paid $0.00. The requester believes it is entitled to an additional $1,155.00. Texas Mutual received the DWC60 from the provider. Per documentation in the DWC60 packet the provider has not fully complied per Rule 133.307(C)(2)(N). No position statement, EOB with denial or appeal has been received. For the reasons noted above, Texas Mutual is not able to appropriately respond regarding the disputed service in question."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
September 30, 2020	72141	$1,155.00	$352.36

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

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 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
3. Neither party submitted copies of EOBs with the DWC060 dispute/response.

Issue(s)

1. Did the requestor comply with 28 TAC 133.307 (C)(2)?
2. What is the definition of CPT Code 72141?
3. What is the applicable rule for determining reimbursement for the service in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 72141 rendered on September 30, 2020.

   28 TAC §133.307 (C)(2)(K) states, "(K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." The requestor submitted internal notes documenting a request for an EOB from the insurance carrier. Therefore, the requestor met the requirements of 28 TAC §133.307 (C)(2)(K).

   28 TAC §133.307 (C)(2)(N) states, "(N) a position statement of the disputed issue(s) that shall include."

   The requestor submitted copies of internal notes documenting the reasons for nonpayment. As a result, the requestor met the requirements of 28 TAC §133.307 (C)(2)(N).

   The DWC finds that the requestor met the requirements of 28 TAC §133.307 (C)(2)(K) and (C)(2)(N) and as a result, the service in dispute is eligible for review by MFDR.

2. 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 requestor billed CPT Code 72141 defined as "Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material."

   The requestor did not append modifier TC or 26, therefore billing for the whole procedure.

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).

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 79761, which is located in Odessa, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

   The 2020 DWC conversion factor for this service is 60.32. The 2020 Medicare Conversion Factor is 36.0896

   The Medicare participating amount for 71241 at this location is $210.82. Using the above formula, the division finds the MAR is $352.36. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $352.36.

4. Review of the submitted documentation finds that the requestor is therefore entitled to reimbursement in the amount of $352.36.

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 $352.36.

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 reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $352.36 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 18, 2021
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.