



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

MEMORIAL MRI & DIAGNOSTIC

Respondent Name

STANDARD FIRE INSURANCE COMPANY

MFDR Tracking Number

M4-22-1729-01

Carrier's Austin Representative

Box Number 5

DWC Date Received

April 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 13, 2021	72148	\$2,756.00	\$389.34
Total		\$2756.00	\$389.34

Requestor's Position

"This bill was rejected due to claim is denied. I spoke with adjuster... where she stated referral for MRI Lumbar needed to go thru preauth and she confirms... is compensable on the claim. I send the referral thru the preauth department and MRI Lumbar was approved under authorization number: 4199599 and service was valid from 06/29/21 to 11/01/21."

Amount in Dispute: \$2,756.00

Respondent's Position

"The Provider is seeking \$2,756. However, the Provider only submitted an initial medical bill. The Provider never submitted a request for reconsideration as required pursuant to Division rule 133.250... Moreover, the Provider's CMS-1500 identified the diagnosis code as... which is a condition that the Carrier has disputed. Pursuant to Division rule 133.305 (b), if there is a request for Medical Fee Dispute Resolution that involves a service in which there is an extent of injury dispute or a compensability or liability dispute, the compensability or liability or extent of injury dispute must be resolved first. Accordingly, the Provider's request for Medical Fee Dispute Resolution should be dismissed until the underlying issues are resolved."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §133.250 sets out the requirements for reconsideration of a medical bill.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 5050 – Claim is denied. No payment will be made.
- P4 – Workers' Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
- N612 – Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patient's responsibility unless the workers' compensation state law allows the patient to be billed.

Issues

1. Is the Requestor eligible for medical fee dispute resolution?
2. Is the Insurance Carrier's denial reason(s) supported?
3. What is the definition of CPT Code 72148?
4. Is the Requestor entitled to reimbursement?

Findings

1. The health care provider is permitted to file for medical fee dispute resolution only after it has filed for reconsideration per 28 TAC §133.250 (a) and (i).

The insurance carrier's position summary states, "... the Provider only submitted an initial medical bill. The Provider never submitted a request for reconsideration as required pursuant to Division rule 133.250."

28 TAC §133.250 (g) states that the insurance carrier's deadline to take final action and issue an explanation of benefits is 30 days from the date of receipt of the request for reconsideration. If after 35 days, there is no indication of final action from the insurance carrier, the health care provider may then file for medical fee dispute resolution.

The DWC finds that the fax confirmation submitted by the requestor sufficiently supports that the Requestor made an attempt to request a reconsideration audit prior to the filing of the DWC060. For that reason, the service in dispute is eligible for medical fee dispute resolution review.

2. The Requestor seeks reimbursement for CPT Code 72148 rendered on July 13, 2021. The insurance carrier denied/reduced the CPT Code with denial reductions codes indicated above.

The insurance carrier states in part, "Moreover, the Provider's CMS-1500 identified the diagnosis code as... which is a condition that the Carrier has disputed. Pursuant to Division rule 133.305 (b), if there is a request for Medical Fee Dispute Resolution that involves a service in which there is an extent of injury dispute or a compensability or liability dispute, the compensability or liability or extent of injury dispute must be resolved first. Accordingly, the Provider's request for Medical Fee Dispute Resolution should be dismissed until the underlying issues are resolved."

The service in dispute was denied by the workers' compensation carrier due to an unresolved extent of injury issue. 28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

Review of the documentation submitted by the parties, finds that the carrier did not provided documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by 28 TAC §133.307(d)(2)(H). The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the division finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is ripe for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines

3. 28 TAC §134.203(b)(1) states, "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 disputed CPT Code 72148 is defined as "Magnetic resonance (eg, proton) imaging, spinal canal, and contents, lumbar; without contrast material."

The Requestor did not append a modifier to the radiology code, which indicates that the whole procedure was performed.

4. 28 TAC §134.203 states, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of... Radiology... when performed in an office setting, the established conversion factor to be applied is \$52.83... (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 Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931
- CMS 1500s indicated that the services were rendered in zip code 77449; therefore, the Medicare locality is "Houston, Texas."
- The Medicare Participating amount for CPT code 72148 at this locality is \$222.09.
- Using the above formula, the DWC finds the MAR is \$389.34.
- The respondent paid \$0.00.
- Reimbursement of \$389.34 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of \$389.34 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$389.34 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	May 13, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.