TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MEMORIAL MRI & DIAGNOSTIC

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-23-1647-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
March 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 13, 2022	73721	$2,756.00	$0.00
	Total	$2,756.00	$0.00

Requestor's Position

"It appears to be the first MRI but you might want to verify with Mitchell to make sure it doesn't require pre-auth (if it's a repeat)."

Amount in Dispute: $2,756.00

Respondent's Position

"This has been reviewed per your request, as the prior review were denied for entitlement)non-compensable), as the date of service was prior to the filing for dispute. Additional allowance is made for $402.40, including $.98 interest, for amended amount of $403.38."

Response Submitted by: Mitchell

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- 268 – Entitlement (non-compensable).
- P4 – Workers' compensation claim adjudicated as non-compensable. This payer is not liable for the claim or service/treatment.

Issues

1. Is the insurance carrier's denial reason supported?
2. What rule applies to the reimbursement of the disputed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 73721 rendered on October 13, 2022. The insurance carrier denied the disputed service with denial reduction codes indicated above.

   The insurance carrier states, "Additional allowance is made for $402.40, including $.98 interest, for amended amount of $403.38."

   Review of the documentation submitted, finds that the insurance carrier submitted a copy of a check dated March 27, 2023, check #297622 for $.98 interest and check #297620 for $402.40 issued on March 24, 2023, for disputed CPT Code 73721 issued to Memorial MRI and Diagnostic. The DWC will now consider if the insurance carrier issued the fee guideline amount in accordance with 28 TAC §134.203.

2. The requestor seeks reimbursement for 73721 rendered on October 13, 2022.

   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 73721 is described as "Magnetic resonance (e.g., proton) imaging, any joint of lower extremity."

Modifier LT was appended. Modifier LT identifies that the procedure was performed on the left.

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

3. Per 28 TAC §134.203 sets out the guidelines for radiology services.

   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 Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2022 DWC Conversion Factor is 62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the services were rendered in zip code 75080; therefore, the Medicare locality is "Dallas."
   - The Medicare Participating amount for CPT code 73721 at this locality is $222.95.
   - Using the above formula, the DWC finds the MAR is $402.40.
   - The respondent paid $402.40.
   - The requestor seeks $2,756.00
   - Reimbursement of $0.00 is recommended.

4. The DWC finds that due to the reasons indicated above, the requestor is not entitled to additional reimbursement for CPT Code 73721.

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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed service.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 5, 2023 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 electronico CompConnection@tdi.texas.gov.