**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
RITESH R. PRASAD, MD

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**
M4-21-1863-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
JUNE 17, 2021

## *REQUESTOR'S POSITION SUMMARY*

"I am requesting that his claim be paid as filed as we did our jobs in getting it preauthorized and filed correctly as a clean claim and per Medicare guidelines."

**Amount in Dispute:** $2,697.00

## *RESPONDENT'S POSITION SUMMARY*

The respondent did not submit a response to this request for medical fee dispute resolution.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 21, 2021 | CPT Code 64490-LT | $1,798.00 | $334.85 |
| | CPT Code 64491-LT | $899.00 | $169.07 |
| TOTAL | | $2,697.00 | $503.92 |

## *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, effective February 22, 2021, sets out the procedures for resolving a medical fee dispute.
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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 5399-Documentation does not include a copy of the images, or a statement that images have been recorded, or that equipment cannot store images.

- 252-An attachment/other documentation is required to adjudicate this claim/service.
- 00563,193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

Is the requestor entitled to reimbursement for CPT codes 64490-LT and 64491-LT rendered on January 21, 2021?

**Findings**

1. The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson received a copy of this medical fee dispute on June 22, 2021. 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).

2. The requestor is seeking medical fee dispute resolution in the amount of $2,697.00 for CPT codes 64490-LT and 64491-LT rendered on January 21, 2021.

3. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   - 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 §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."

4. The disputed services are described as:

   - 64490-Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
   - 64491-Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure).

5. CPT codes 64490-LT and 64491-LT:

   The respondent denied reimbursement for CPT codes 6440-LT and 64491-LT based upon reason codes "5399," "252," and "P12." (code description listed above)

   Review of the Procedure Note report supports claimant underwent a "LT C2-C4 Medical Branch Blocks under fluoroscopic guidance. The report contains a Radiology Note. The requestor supported billing CPT codes 64490 and 6449; therefore, reimbursement per the fee guideline is recommended.

   Per 28 TAC §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the DWC had been using this MEI annual percentage adjustment: The 2006 DWC conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI

annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) DWC conversion factor in 2007."

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

The requestor noted on the CMS-1500 the Place of Service was "11" for an office setting.

The 2021 DWC Conversion Factor is 60.32

The 2021 Medicare Conversion Factor is 36.0896

Per the CMs 1500, the services were rendered in Tyler, TX; therefore, the Medicare locality is "Rest of Texas".

Using the above formula, the DWC finds the MAR is:

| Code | Medicare Participating Amount | MAR | Insurance Carrier Paid | Amount Due |
|---|---|---|---|---|
| 64490 | $191.01 | $334.85 | $0.00 | $334.85 |
| 64491 | $96.44 | $169.07 | $0.00 | $169.07 |

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $503.92.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $503.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 08/17/2021<br>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**.