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
Indemnity Insurance Company

MFDR Tracking Number
M4-23-2275-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
May 12, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 19, 2023	Q9967, J1100, A4550, A4215, 99211, 62321 and J2001	$2,753.00	$0.00
	Total	$2,753.00	$0.00

Requestor's Position

"This bill was rejected due to documentation does not include a copy of the images, or a statement that images have been recorded, or that equipment cannot store images. Patient had a Cervical ESI where no images are available, just a report. Please see attached and reconsider for payment."

Amount in Dispute: $2,753.00

Respondent's Position

"We have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review."

Submitted by: Gallagher Bassett

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.
4. 28 TAC §134.1 sets out the medical reimbursement policies.

Denial Reasons

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

- 90563 & 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 & 90223 – Workers Compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 252 – An attachment of other documentation is required to adjudicate this claim/service.
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 90136 & 96 – non-covered charge(s).
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 237 – Legislated regulatory penalty.
- 242 – Services not provided by network/primary care providers.
- 4480 – Recommended allowance has been authorized by the payor.
- 5399 – Documentation does not include a copy of the images, or a statement that images have been recorded, or that equipment cannot store images.
- 76 – Disproportionate share adjustment.

Issues

1. What are the services in dispute?
2. Did the insurance carrier issue an additional payment for CPT Code 62321?
3. Is the requestor entitled to reimbursement for HCPCS code Q9667?
4. Is the requestor entitled to reimbursement for HCPCS code A4550, and A4215?
5. Is the requestor entitled to reimbursement for HCPCS code J1100, and J2001?
6. Is the requestor entitled to reimbursement for CPT code 99211?
7. Is the requestor entitled to additional reimbursement?

Findings

1. The reduced payment for professional services performed on January 19, 2023, billed under HCPC codes Q9967, J1100, J2001, A4550, A4215, and CPT codes 99211-25 and 62321, is the subject of this dispute. The requester is seeking a payment of $2,753.00. The insurance carrier audited, made a partial payment, and denied the outstanding amount using the above-mentioned denial reduction codes.

   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."

   The HCPCs Code descriptions of the services in dispute include:

   Q9967 – Low osmolar contract material, 300-399 mg/ml iodine concentration, per ml.

   J1100 – Injection, dexamethasone sodium phosphate, 1 mg.

   A4550 – Surgical tray.

   A4215 – Needle, sterile, any size, each.

   J2001 – Injection, lidocaine HCI for intravenous infusion, 10 mg.

   The CPT Code descriptions with modifier if applicable of the services in dispute include:

   99211 25 – Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Modifier 25 is defined as a Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

   62321 – Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical, or thoracic; with imaging guidance (ie, fluoroscopy or CT).

2. The insurance carrier denied reimbursement for CPT code 62321 with code "252- An attachment of other documentation is required to adjudicate this claim/service."

   A review of the submitted Procedure Note supports the billed service; therefore, reimbursement is recommended.

   The fee guidelines for disputed services are found in 28 TAC §134.203.

   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(c)(1) states "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."

   28 Texas Administrative Code §134.203(c)(2) states "The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. The 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 Division had been using this MEI annual percentage adjustment: The 2006 Division 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) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Page 4 of 5 Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77449; the Medicare locality is Houston.
   - The carrier code for Texas is 4412 and the locality code for Houston is 18.
   - The Medicare participating amount for CPT code 62321 in this locality is $271.62.
   - The Place of Service is 11-Office.
   - The DWC conversion factor for 2023 is 64.83.
   - The Medicare conversion factor for 2023 is 33.8872.
   - Using the above formula, the MAR is $519.64. The respondent paid $519.64 under check #296454170, dated June 2, 2023.
   - The requestor is due $0.00.

3. The requestor billed $33.00 for HCPCS codes Q9967 x 3 units. The respondent paid $0.66.

   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(d)(1)(2) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

   HCPCS code Q9967 does not have a fee listed in DMEPOS fee schedule. "(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS." HCPCS code Q9967 does not have a fee listed in DMEPOS fee schedule. "(3) which states "if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   28 TAC §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 TAC §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   The requestor did not submit documentation to support the requested amount of $11.00, as required by 28 TAC §134.1. No additional reimbursement is recommended.

4. The requestor seeks reimbursement for HCPCS code A4215 and A4550 rendered on January 19, 2023. 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."

   Per Publication 100-04 Medicare Claims Processing policy A4215 and A4550 are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service. As a result, reimbursement is not recommended.

5. The requestor seeks reimbursement for HCPCS code J1100 and J2001 rendered on January 19, 2023. The NCCI manual indicates that J1100 and J2001 are packaged codes integral to the total service package with no separate payment. No payment is recommended for HCPCs code J1100 and J2001.

6. The requestor seeks reimbursement for CPT code 99211 rendered on January 19, 2023. Review of the Medicare National Correct Coding Initiative Policy Manual, Chapter Four, Section B states in pertinent part, "In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25."

   The 25 modifier is defined as It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

   A review of the submitted medical documentation indicates the claimant was seen and it was determined that a cervical epidural steroid injection was required. Based on this review, insufficient documentation was found to support the E/M service was unrelated to the decision to perform the minor procedure. The insurance carrier's denial is supported. No payment is recommended.

7. The DWC finds that the requestor is not entitled to additional reimbursement for the disputed services.

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 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 services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 2, 2024 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. Please contact CompConnection by email at CompConnection@tdi.texas.gov or by phone at 1-800-252-7031, option 3, if you have any questions or concerns regarding the DWC Form-045M.

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.