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 Co. of North America

MFDR Tracking Number
M4-24-2110-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
May 31, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 8, 2024	73221 – RT	$2,756.00	$427.04
	Total	$2,756.00	$427.04

Requestor's Position

"I received a denial for d/s 02/08/2024. This bill was rejected due to this was denied by UR. Referral came from Designated Doctor and according to the Texas Administrative Code, Rule 127.10 (c) does not need pre-authorization. Please see attached and reconsider for payment. Thank you for your prompt attention in this matter."

Amount in Dispute: $2,756.00

Respondent's Supplemental Position

"Denied as duplicate."

Response 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 general provisions for the dispute of medical bills.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §127.10 sets out the general procedures and requirements for Designated Doctor examinations.
4. 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:

- P6 – Based on entitlement to benefits.
- Additional comments: This was denied by UR
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 93 – No claim level adjustments.
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 5263-1 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract or carrier decision.

Issues

1. What rules apply to the service in dispute?
2. Is the insurance carrier's denial supported?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of magnetic resonance imaging (MRI) services rendered on February 8, 2024, and billed under CPT code 73221-RT. Per documentation submitted and information known to DWC, the disputed service was referred to the requestor by a designated doctor to help resolve the question of whether the injured employee's injury had reached maximum medical improvement (MMI).

   DWC finds that 28 TAC §127.10(c) applies to the designated doctor referred service in dispute, stating in pertinent part, "(c) Additional testing and referrals. The designated doctor must perform additional testing when necessary to resolve the issue in question. The designated doctor must also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question, and the designated doctor is not qualified to fully resolve it. (1) Any additional testing or referrals required for the evaluation are not subject to preauthorization requirements. (2) Payment for additional testing or referrals that the designated doctor has determined are necessary under this subsection must not be denied prospectively or retrospectively, regardless of any potential disagreements about medical necessity, extent of injury, or compensability."

   28 TAC §134.203, which applies to the billing and reimbursement of the service in dispute, states "(b) 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… (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."

2. The requestor is seeking reimbursement for a medical imaging service, MRI, referred by a designated doctor. The insurance carrier denied the services in dispute based on entitlement to benefits and utilization review. The denial reasons are related to a potential dispute of compensability, extent of injury or liability and to medical necessity.

   In accordance with 28 TAC §127.10(c), quoted in finding number one, payment for additional testing or referrals that the designated doctor has determined are necessary must not be denied prospectively or retrospectively, regardless of any potential disagreements about medical necessity, extent of injury, or compensability.

Therefore, DWC finds that the insurance carrier's reasons for denial are not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

3. The requestor seeks reimbursement in the amount of $2,756.00 for one unit of CPT code 73221 rendered on February 8, 2024.

   CPT code 73221 is defined as "Magnetic resonance imaging, any joint of upper extremity; without contrast material(s)."

   The requestor appended informational modifier "RT" indicating that the procedure was performed on the right side of the body.

   In accordance with 28 TAC §134.203, which applies to the billing and reimbursement of the disputed service, the following formula is used to determine the maximum allowable reimbursement (MAR):

   (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

   - The 2024 DWC Conversion Factor is 67.81
   - The 2024 Medicare Conversion Factor is 32.7442
   - A review of the medical bills finds that the disputed services were rendered in zip code 75080; the Medicare locality is 11, "Dallas".
   - The Medicare Participating amount for CPT code 73221 at this locality in 2024 is $206.21.
   - Using the above formula DWC finds that the MAR is $427.04.
   - The respondent paid $0.00.
   - Reimbursement in the amount of $427.04 is recommended for one unit of CPT code 73221 rendered on February 8, 2024.

   DWC finds that the requestor is entitled to reimbursement for the disputed services. As a result, $427.04 is due.

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.

DWC finds the requestor has established that reimbursement in the amount of $427.04 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, Indemnity Insurance Co. of North America must remit to the requestor, Memorial MRI & Diagnostics $427.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 8, 2024
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, 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.