



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

SOUTH TEXAS RADIOLOGY IMAGING

Respondent Name

MONTGOMERY WARD/TCSIGA

MFDR Tracking Number

M4-15-0013-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

SEPTEMBER 2, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received partial payment for dates of service 3/25/14 & 3/26/14."

Amount in Dispute: \$1,778.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge for Code A9570 in the amount of \$2,600.00 was disputed as included in the payment/allowance for another service already adjudicated. In addition, the charge for Code A9503 dated 03/25/2014 in the amount of \$40.00 was also disputed as included in the payment / allowance for another service already adjudicated. The disputed charges were re-audited on 08/04/2014 and the carrier's original payment decisions were maintained ."

Response Submitted by: Parker & Associates, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2014	HCPCS Code A9503	\$16.98	\$16.98
March 26, 2014	HCPCS Code A9570	\$1,761.69	\$1,761.69
TOTAL		\$1,778.67	\$1,778.67

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.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.

Issues

1. Is the allowance for code A9503 included in the allowance of code 78315?
2. Is the allowance for code A9570 included in the allowance of code 78806?

Findings

1. On March 25, 2014, the requestor billed HCPCS codes A9503 and 78315.

- CPT code 78315 is defined as “Bone and/or joint imaging; 3 phase study.”
- HCPCS code A9503 is defined as “Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries.”

28 Texas Administrative Code §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 Texas Administrative Code 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 HCPCS code S9088 does not have a relative value unit or payment; therefore, reimbursement for these services are set out in 28 Texas Administrative Code §134.203(f).

Per CCI edits, HCPCS code A9503 is not a component on code 78315; therefore, the respondent’s denial based upon reason code “97” is not supported.

28 Texas Administrative Code §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 A9503 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.”

Per the Texas Medicaid fee schedule code A9503 has a fee of \$16.58. Therefore, the MAR is \$16.58 X 125% = \$20.72. The requestor is seeking \$16.98, this amount is recommended for reimbursement.

2. On March 26, 2014, the requestor billed HCPCS codes A9570 and 78806.

- HCPCS code A9570 is defined as “Indium In-111 labeled autologous white blood cells, diagnostic, per study dose.”
- CPT code 78806 is defined as “Radiopharmaceutical localization of inflammatory process; whole body.”

Per CCI edits, HCPCS code A9570 is not a component on code 78806; therefore, the respondent’s denial based upon reason code “97” is not supported.

Per 28 Texas Administrative Code §134.203(d)(1)(2), HCPCS code A9570 does not have a fee schedule in DMEPOS or Texas Medicaid. The Division refers to 28 Texas Administrative Code §134.203(d)(3) which states “if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

28 Texas Administrative Code §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 Texas Administrative Code §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 submitted a copy of an invoice that indicates the cost for code code A9570 is \$1,761.69. The Division considers the invoice supports the amount sought for reimbursement. As a result, this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$1,778.67.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,778.67 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

01/21/2015
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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.