



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Rezik A Sager MD

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-15-0855-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

November 7, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "In order to be sure that the patient is in compliance with the treatment plan as set up for him/her and in compliance with the Official Disability Guidelines, it is our protocol of care to perform random drug screens at an intermediate risk level. Which the ODG states a 3-4 time a year frequency is recommended for the patients at intermediate risk."

**Amount in Dispute:** \$840.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor did not request reconsideration of the denial of payment for date of service 12/18/2013... The requestor has waived its right to dispute resolution on dates of service 2/22/2013 & 9/20/2013 because the filing was late."

**Response Submitted by:** Texas Mutual

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2013 September 20, 2013 December 18, 2013	G0431	\$840.00	\$124.16

#### 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 sets out the reimbursement guidelines for clinical laboratory services
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 225 – The submitted documentation does not support the service being billed
  - 18 – Exact duplicate claim/service

## **Issues**

1. Was the request for MFDR submitted timely?
2. Did the requestor support that appeal was made for services in dispute?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is February 22, 2013 and September 20, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 7, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of service.
2. The respondent in their position statement asserts, "The requestor did not request reconsideration of the denial of payment for date of service 12/18/2013..." Review of the submitted documentation finds
  - a. Original adjudication date of audit 03/03/2014
  - b. Second explanation of benefits dated 08/04/2014, with denial as "exact duplicate claim/service"

The Division finds the respondent's position statement is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

3. For date of service December 18, 2013 that is eligible for dispute, 28 TAC §134.203(e) states:

"The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

  - (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and
  - (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2014 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov> or;

$$(\text{TDI-DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Non-Facility Price} = \text{MAR} \text{ or } (55.3 / 34.023) \times \$76.39 = \$124.16$$

4. The total allowable reimbursement for the services in dispute is \$124.16. The Carrier previously paid 0.00 . The remaining balance of \$124.16 is due to the requestor.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$124.16.

**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 \$124.16 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

\_\_\_\_\_  
Date

April , 2015

**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.**