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
Texas Pain Solutions

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-15-0871-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 10, 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: "Certainly, at least by the time the request for reconsideration was made to Texas Mutual, the provider was aware that Texas Mutual was requesting further documentation. Even assuming the documentation was required to be submitted with the initial billing, Texas Mutual had the right to retrospectively review the services."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2013, November 1, 2013 and December 27, 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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §137.100 sets out treatment guidelines
3. 28 Texas Administrative Code §133.240 sets out procedures for medical payment and denials
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 6 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 758 – ODG documentation requirements for urine drug testing have not been met

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Were the disputed dates of services filed to Medical Fee Dispute Resolution timely?
2. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
3. What is the applicable rule related to reimbursement guidelines?
4. Is reimbursement due?

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 July 12, 2013 and November 1, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 10, 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 carrier, in its response to this medical fee dispute, makes assertions that "…Texas Mutual has the right to retrospectively review the services." 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

   "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary." 28 TAC §19.2015(b) titled *Retrospective Review of Medical Necessity* states:

   (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

   The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

3. For date of service December 27, 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;

(TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = MAR or (55.3 / 34.023) x $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 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

		April , 2015
Signature	Medical Fee Dispute Resolution Manager	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.