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 Medclinic

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-15-1291-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since we are CLIA certified and there is no know Medicare billing policy that requires a modifier be used when billing for lab procedures, the services that were denied should have been paid."

Amount in Dispute: $144.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A CLIA certification is one portion of the requirement. Modifier QW should be submitted with laboratory tests that are waived…"

Response Submitted by: CorVel Corporation, 3721 Executive Center Drive, Suite 201, Austin, TX 78731

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2014	87340, 86317, 86803, 86703, 84460	$144.90	$0.00

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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – Required Modifier Missing or Inconsistent w/procedure
   - RP3 – CMS statutory exclusion/svc not paid to physicians

Issues

1. Did the requestor comply with Division guidelines when the medical claim was submitted?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 4 – "Required modifier missing or inconsistent w/procedure." 28 Texas Labor Code §134.203 (b) states in pertinent part, "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;…" Review of the submitted documentation finds;
    a. Codes submitted are defined as clinical laboratory services
    b. CLIA waiver submitted by requestor states, "Certificate of Provider-Performed Microscopy Procedures". With notation, "If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

   The Medicare Claims Processing Manual, Chapter 16, states in pertinent part, 70.8 - Effective September 1, 1992, all laboratory testing sites (except as provided in 42 CFR 493.3(b)) must have either a CLIA certificate of waiver, certificate for provider-performed microscopy procedures, certificate of registration, certificate of compliance, or certificate of accreditation to legally perform clinical laboratory testing on specimens from individuals in the United States. The Food and Drug Administration approves CLIA waived tests on a flow basis. The CMS identifies CLIA waived tests by providing an updated list of waived tests to the Medicare contractors on a quarterly basis via a Recurring Update Notification. To be recognized as a waived test, some CLIA waived tests have unique HCPCS procedure codes and some must have a QW modifier included with the HCPCS code. For a list of specific HCPCS codes subject to CLIA see http://www.cms.hhs.gov/CLIA/downloads/waivetbl.pdf." Review of this list finds submitted code 86803 and 84460 are considered "Waived" tests and require the QW modifier. The Carrier's denial is supported.

   The Carrier denied the remaining codes in dispute (87340, 86317, and 86703) as above and also as RP3 – "CMS statutory exclusion/svc not paid to physicians." The Medicare Claims Processing Manual, Chapter 16, defines the type of CLIA certificate held by the requestor as, "70.6 - Certificate for Provider-Performed Microscopy Procedures, Implementation: 07-03-06) Effective January 19, 1993, a laboratory that holds a certificate for provider-performed microscopy procedures may perform only those tests specified as provider-performed microscopy procedures and waived tests, as described below, and no others.

HCPCS Code	Test
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous
81015	Urinalysis; microscopic only
81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy (NOTE: May only be used when the lab is using an automated dipstick urinalysis instrument approved as waived.)
81020	Urinalysis; two or three glass test
89055	Fecal leukocyte examination
89190	Nasal smears for eosinophils
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner

   The Carrier's denial of the remaining codes is supported at the type of CLIA license held by the requestor does not allow the services performed.

2. Provisions of Rule 134. 203 have were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April , 2015
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 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.