



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Compliance Toxicology

Respondent Name

Texas Municipal League Intergovernmental Risk Pool

MFDR Tracking Number

M4-15-1693-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier ... made a partial payment on 1/15/15."

Amount in Dispute: \$1645.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denied additional reimbursement because the services provided were not documented to have been ordered by Dr. Strausser, and the documentation attached did not support the services provided were medically necessary at the time."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2014	Urinary Drug Test	\$1645.00	\$641.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §133.210 sets out the documentation requirements for bill submission.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information or has billing/submission error(s) which is needed for adjudication.
 - Notes: "16 – PLEASE SUBMIT LETTER OF MEDICAL NECESSITY FROM PRESCRIBING DOCTOR."
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is procedure code G0431 part of the current medical fee dispute?
2. Did the insurance carrier request additional information in accordance with 28 Texas Administrative Code §133.210?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. While procedure code G0431 was included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking \$0.00 for this service. Therefore, this service is not considered for this dispute.
2. The insurance carrier denied disputed services with claim adjustment reason code 16 – “Claim/service lacks information or has billing/submission error(s) which is needed for adjudication.” This was further explained by a comment stating, “16 – PLEASE SUBMIT LETTER OF MEDICAL NECESSITY FROM PRESCRIBING DOCTOR.”

Documentation requirements for medical bills are established by 28 Texas Administrative Code §133.210, which does not require documentation to be submitted with the medical bill for the services in dispute. Further, the process for a carrier’s request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in subsection (d) as follows:

Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

Review of the submitted documentation does not support that the insurance carrier made a request for additional information with the specificity required by 28 Texas Administrative Code §133.210(d).

3. 28 Texas Administrative Code §134.203(b) 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.

28 Texas Administrative Code §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) percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

The Division finds that the services in dispute are not addressed in 28 Texas Administrative Code §134.203 (c)(1).

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 2015 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov>.

MAR for these services is calculated as follows:

Procedure Code	CMS Fee Schedule	134.203(e)(1)	Units	Paid	Requestor Seeking	Amount Due
82570	\$7.06	$\$7.06 \times 1.25 = \8.83	1	\$0.00	\$35.00	\$8.83
83986	\$4.88	$\$4.88 \times 1.25 = \6.10	1	\$0.00	\$35.00	\$6.10
82542	\$24.63	$\$24.63 \times 1.25 = \30.79	1	\$0.00	\$60.00	\$30.79
80154	\$25.23	$\$25.23 \times 1.25 = \31.54	1	\$0.00	\$80.00	\$31.54
80299	\$18.68	$\$18.68 \times 1.25 = \23.35	2	\$0.00	\$140.00	\$46.70
82145	\$21.20	$\$21.20 \times 1.25 = \26.50	1	\$0.00	\$60.00	\$26.50
82205-59	\$15.62	$\$15.62 \times 1.25 = \19.53	1	\$0.00	\$70.00	\$19.53
82520	\$20.68	$\$20.68 \times 1.25 = \25.85	2	\$0.00	\$130.00	\$51.70
83840	\$22.28	$\$22.28 \times 1.25 = \27.85	2	\$0.00	\$140.00	\$55.70
83925	\$26.54	$\$26.54 \times 1.25 = \33.18	4	\$0.00	\$320.00	\$132.72
83805	\$24.04	$\$24.04 \times 1.25 = \30.05	1	\$0.00	\$80.00	\$30.05
82646	\$28.17	$\$28.17 \times 1.25 = \35.21	1	\$0.00	\$85.00	\$35.21
82649	\$35.07	$\$35.07 \times 1.25 = \42.84	1	\$0.00	\$85.00	\$42.84
82205-59	\$15.62	$\$15.62 \times 1.25 = \19.53	1	\$0.00	\$70.00	\$19.53
83789-59	\$24.63	$\$24.63 \times 1.25 = \30.79	1	\$0.00	\$65.00	\$30.79
80152	\$24.42	$\$24.42 \times 1.25 = \30.53	1	\$0.00	\$60.00	\$30.53
80182	\$18.49	$\$18.49 \times 1.25 = \23.11	1	\$0.00	\$65.00	\$23.11
80184	\$15.62	$\$15.62 \times 1.25 = \19.53	1	\$0.00	\$65.00	\$19.53
					Total	\$641.70

4. The total MAR for the disputed services is \$641.70. The insurance carrier paid \$0.00. An additional reimbursement of \$641.70 is recommended.

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 \$641.70.

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 \$641.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

March 14, 2016
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, 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 MFDR 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.