



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

Consultants in Pain Medicine

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-15-2639-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We content that Texas Mutual Insurance Company did not apply the 28 Texas Administrative Code Rules and Guidelines when auditing the laboratory services."

Amount in Dispute: \$160.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve the dispute over the other codes Texas Mutual has elected to pay them."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2014	Urinary Drug Screens	\$160.99	\$0.00

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 requirements for filing a medical fee dispute.
- 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:
Explanation of benefits dated November 24, 2014
 - B5 – Coverage/program guidelines were not met or were exceeded
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
 - 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153(C)

- 225 – The submitted documentation does not support the service being billed
- A05 – Service exceeds recommendations of treatment guidelines (ODG)
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Explanation of benefits dated January 28, 2015

- B5 – Coverage/program guidelines were not met or were exceeded
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153(C)
- 225 – The submitted documentation does not support the service being billed
- A05 – Service exceeds recommendations of treatment guidelines (ODG)
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Explanation of benefits dated April 2, 2015

- B5 – Coverage/program guidelines were not met or were exceeded
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 18 – Exact duplicate claim/service
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153(C)
- 225 – The submitted documentation does not support the service being billed
- A05 – Service exceeds recommendations of treatment guidelines (ODG)
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Explanation of benefits dated May 20, 2015

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 18 – Exact duplicate claim/service
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 920 – Reimbursement is being allowed based upon a dispute

Issues

1. Did the respondent support their denial?
2. Is reimbursement due?

Findings

1. This dispute was for multiple drug screen tests. The previous denials for codes 82646, 82649, 83925

and 83925, were not maintained as reimbursement for these codes was made on May 20, 2015. The remaining codes 82570 and 83986 were denied as 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” 28 Texas Administrative 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; 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.

The respondent states, “The requestor billed G0431, 82570, and 83986. Both 82570 and 83986 are validity tests that are performed on the same specimen being tested with code G0431. Validity testing is an internal quality process to affirm the reported results are accurate and valid, and is not separately billable Medicare service.”

Review of the medical bill finds that current AMA CPT Codes were billed. Review of National Correct Coding Initiative Policy Manual for Medicare Services, finds no CCI conflicts or Medicare billing exclusions that apply to the clinical laboratory services in dispute for this date of service. The requestors’ statement is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The services in dispute are eligible for payment. 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>. The total MAR is calculated as follows:

Date of Service	Submitted Code	Submitted Charge	Units	MAR
October 3, 2014	82570	\$40.00	1	\$7.06 x 125% = \$8.83
October 3, 2014	82646	\$45.00	1	\$28.17 x 125% = \$35.21
October 3, 2014	82649	\$45.00	1	\$35.07 x 125% = \$43.84
October 3, 2014	83925	\$45.00	1	\$26.54 x 125% = \$33.18
October 3, 2014	83925	\$45.00	1	\$26.54 x 125% = \$33.18
October 3, 2014	83986	\$40.00	1	\$4.88 x 125% = \$6.10
	Total	\$260.00		\$160.34

The total maximum allowable reimbursement for the services in dispute is \$160.34. The amount previously paid by the Carrier is \$174.95 (less \$2.51 interest) = \$172.44. As a result, the amount ordered is \$0.00.

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

Signature	Medical Fee Dispute Resolution Officer	August , 2015 Date
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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.