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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dennis Slavin MD

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-3119-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I did submit a reconsideration request to Texas Mutual with the additional information they were requesting in the original denial; and they still continue to deny. I enclosed a copy of the procedure note along with approval from preauthorization department and an form with detailed information that pertains to HCPCs code J3490."

Amount in Dispute: $576.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed $1,200.00 for code J3490. The 2014 HCPCS Level II AMA manual defines the code as unclassified drugs. Texas Mutual declined to issue payment for two reasons. First, an epidural steroid injection was given in the office. There are specific HCPCS codes for specific steroids. Second, the documentation does not substantiate the particular drugs that were billed under J3490."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2014	J3490	$576.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code Rule §21.2803 sets out requirements for submission of a clean claim.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

- P12 – Worker's compensation jurisdictional fee schedule adjustment
- 225 – The submitted document does not support the service being billed
- 714 – Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is regarding the payment of HCPCS Code J3490 – "Unclassified drugs". The insurance carrier denied disputed services with claim adjustment reason code 714 – "Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly and 16 Claim/service lacks information or has submission/billing errors(s) which is needed for adjudication." 28 Texas Administrative Code §21.2803 states in pertinent part, (a) Filing a clean claim. A physician or a provider submits a clean claim by providing to an MCC or any other entity designated for receipt of claims under §21.2811 of this title (related to Disclosure of Processing Procedures):

   (1) for nonelectronic claims other than dental claims, the required data elements specified in subsection (b) of this section;

   (b) Required data elements. CMS has developed claim forms that provide much of the information needed to process claims. Insurance Code Chapter 1204 identifies two of these forms, HCFA 1500 and UB-82/HCFA, and their successor forms, as required for the submission of certain claims. The terms in paragraphs (1) - (3) of this subsection are based on the terms CMS used on successor forms CMS-1500 (02/12), CMS-1500 (08/05), UB-04 CMS-1450, and UB-04. The parenthetical information following each term and data element refers to the applicable CMS claim form and the field number to which that term corresponds on the CMS claim form. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or refiled by physicians or noninstitutional providers are set out in paragraphs (1) and (2) of this subsection. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or refiled by institutional providers are set out in paragraph (3) of this subsection.

   (1) Required form and data elements for physicians or noninstitutional providers for claims filed or refiled on or after the later of April 1, 2014, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form for Medicare claims. The CMS-1500 (02/12) claim form and the data elements described in this paragraph are required for claims filed or refiled by physicians or noninstitutional providers on or after the later of these two dates: April 1, 2014, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form for Medicare claims. The CMS-1500 (02/12) claim form must be completed in compliance with the special instructions applicable to the data elements as described by this paragraph for clean claims filed by physicians and noninstitutional providers. Further, on notification that an MCC is prepared to accept claims filed or refiled on form CMS-1500 (02/12), a physician or noninstitutional provider may submit claims on form CMS-1500 (02/12) before the mandatory use date described in this paragraph, subject to the required data elements set out in this paragraph. (Z) **procedure/modifier code(s) (CMS-1500 (02/12), field 24D) is required. If a physician or a provider uses an unlisted or not classified procedure code or a National Drug Code (NDC), the physician or provider must enter a narrative description of the procedure or the NDC in the shaded area above the corresponding**

   Review of the submitted information finds that the submitted claim contained "J3490"with a description of "Unclassified drugs." The required narrative description was not found. Therefore, the submitted claim did not meet the requirements of Rule §21.2803. The carrier's denials are supported.

2. The claim as submitted did not meet requirements of Division rules. Therefore, 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

		July , 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, 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.