



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

Texas Bone and Joint Center

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-15-3344-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

June 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted by the requestor.

Amount in Dispute: \$1,510.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With regard to CPT codes denied, the three CPT codes in dispute, 82542, 83925, and 82145, were each billed multiple times for multiple testing. Each CPT code was paid for at least one test with the subsequent test disallowed based on mutually exclusive edits. Therefore, no additional reimbursement is owed due to those mutually exclusive edits."

Response Submitted by: Downs ♦ Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2014	82542, 83925, 82145 82542-91, 83925-91, 83925-91, 82145-91	\$1,510.30	\$159.22

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 §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - W3 – Additional payment made on appeal/reconsideration
 - 5417 – Disallowed due to mutually exclusive edits
 - 6578 – Professional Review has been performed on this bill

- 193 – Original payment decision is being maintained
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Did the requestor meet the requirements outline in 28 Texas Administrative Code §134.203 (b)?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 5417– “Disallowed due to mutually exclusive edits.” 28 Texas Administrative Code §134.203 (b) requires that 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 requestor seeks reimbursement for CPT Code 82542 defined by the AMA CPT Code book as “Column chromatography/mass spectrometry.”

- The requestor billed CPT Code 82542-91 x 7 units, 82542-91 x 7 unit and 82542 x 1 for a total of 15 units billed on multiple claim lines. The insurance carrier reimbursed the requestor for 6 units of CPT Code 82542. The requestor seeks the additional 9 units of CPT Code 82542.
- The CMS Medically Unlikely Edits listing found at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html> finds that CPT Code 82542 is billed with a maximum of 6 units. As a result, the insurance carrier’s denial is supported and additional reimbursement cannot be recommended for this service.

The requestor seeks reimbursement for CPT Code 83925 defined by the AMA CPT Code book as “Assay of opiates.”

- The requestor billed CPT Code 83925 x 1 unit, 83925 -91 x 1 unit and 83925 -91 x 1 unit, 83925 -91 x 1 unit for a total of 8 units billed on multiple claim lines.
- The insurance carrier reimbursed the requestor for 4 units of CPT Code 83925. The requestor seeks reimbursement for the additional 4 units of CPT Code 83925. Review of the CMS MUE’s list finds no listing for this CPT code.

The requestor seeks reimbursement for CPT Code 82145 defined by the AMA CPT Code Book as “Assay of amphetamines.”

- The requestor billed CPT Code 82145 x 1 unit, 82145-91 x 1 unit and 82415-91 x 1 on multiple claim lines. The insurance carrier reimbursed the requestor for 2 units of 82145. The requestor seeks reimbursement for one additional unit of CPT Code 82145-91. Review of the CMS MUE’s list finds no listing for this CPT code.
- The request included the -91 modifier on multiple claim lines. The CMS Medicare Claims Processing Manual, Chapter 16, Section 100.51 states in pertinent part, “When it is necessary to obtain multiple results in the course of treatment, the modifiers 59 or 91 are used to indicate that a test was performed more than once on the same day for the same patient.” The requestor met 28 TAC §134.203 (b).

- As a result, the insurance carrier's denial reason is not supported for CPT Codes 83925 and 82145. The disputed services will therefore be reviewed pursuant to the applicable Division rules and fee guidelines.

2. 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) 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 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:

$$82145 - \text{Allowable } \$21.20 \times 125\% = \$26.50 \times 1 \text{ (number of units)} = \$26.50$$

$$83925 - \text{Allowable } \$26.54 \times 125\% = \$33.18 \times 4 \text{ (number of units)} = \$132.72$$

The total allowable for the services in dispute is \$159.22. This amount is recommended.

3. The total recommended payment for the services in dispute is \$159.22. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$159.22. This amount 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 \$159.22.

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 \$159.22 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

<p style="text-align: center;">Peggy Miller</p>	<p style="text-align: center;">August , 2015</p>	
<p>Signature</p>	<p>Medical Fee Dispute Resolution Officer</p>	<p>Date</p>

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.