



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

Mitsui Sumitomo Insurance Co

MFDR Tracking Number

M4-16-0410-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$3,501.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the dispute charges are consistent with applicable guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2015	Urinary Drug Screens	\$3,501.53	\$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 procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
- 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:
 - 16 – Svc lacks info needed or has billing error(s)

- RM7 – Invalid code for CMS payment resubmit w/valid code
- 4 – required modifier missing or inconsistent w/procedure
- W3 – Appeal / Reconsideration

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed codes 80346, 80361, 80364, 80336, 80368, 80370, 80373, 80372, 80367, 80324, 80365, 80356, 80348, 80354, 80366, 80332, 80349, 80358, 80359, 80360, 80353, 80355 and 80345 with claim adjustment reason code RM7 – “Invalid code for CMS payment resubmit w/valid code.”

28 Texas Administrative Code §133.20(c) states, “A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.”

Review of the 2015 CPT codes finds these codes have a Status Indicator of “I” – Not valid for Medicare purposes. Review of the 2015 Clinical Laboratory Fee Schedule found at www.cms.gov finds no listings for these services in dispute. The insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

The submitted code 83992 was denied as RP3 - “CMS statutory exclusion/svc not paid to physicians”. Review of the 2015 CPT codes finds this code has a Status Indicator of “X” – Statutory exclusion. The carrier’s denial is supported. Additional reimbursement cannot be recommended.

2. The remaining code G0434 was denied as B13 – “Payment for service may have been previously paid.” The submitted DWC060 shows paid amount to be \$27.42 for this code. 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.

This code has an allowable of \$15.13 per the applicable fee schedule. This amount multiplied by 125% ($\$15.13 \times 125\%$) = \$18.91

3. The maximum allowable reimbursement for the services in dispute is \$18.91. The carrier previously paid \$27.72. No additional payment is 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

Signature

Peggy Miller
Medical Fee Dispute Resolution Officer

November , 2015
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.