



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 & JOINT CENTER

Respondent Name

WC SOLUTIONS

MFDR Tracking Number

M4-16-0499-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration in this review.

Amount in Dispute: \$3,441.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions, Inc. maintains the position that the drug testing exceeds the ODG and preauthorization was required. Additionally, CPT codes 80324 – 80373 were inactive/invalid codes . . . As such, no reimbursement should be made for these codes . . ."

Response Submitted by: Starr Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: January 9, 2015, Clinical Laboratory Services – Urinary Drug Screening, \$3,441.03, \$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 §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- W3 – Additional reimbursement made on reconsideration.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 181 – Procedure code was invalid on the date of service.
o Medicare should not recognize the additional codes created by CPT for drugs of abuse tests.

- 197 – Payment denied/reduced for absence of precertification/authorization.
 - The drug testing is outside of or exceeds the ODG, therefore, preauthorization is required.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 225 – Penalty or Interest Payment by Payer
 - Interest in the amount of \$7.05 has been applied for 155 entitlement days.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the recommended reimbursement for the disputed professional medical services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 181 – “Procedure code was invalid on the date of service.”

28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply “Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

Review of the submitted information finds that disputed procedure 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

were not valid billing codes on the date of service, per Medicare payment policy. The division thus finds that these disputed codes do not meet the billing requirements of Rule §134.203(b). The insurance carrier’s denial reason is supported. Reimbursement is not recommended.

However, on reconsideration, the insurance carrier did not maintain any dispute as to payment of procedure codes 83992 or G0434-QW. Consequently, the only remaining issues for these two services are the fee issues. These disputed services will therefore be reviewed for payment according to applicable division fee guidelines.

2. This dispute regards clinical laboratory services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. . . .
- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is \$56.20.

Reimbursement is calculated as follows:

- Procedure code 83992 represents a laboratory service with reimbursement determined per §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is \$20.00. 125% of this amount is \$25.00.
- Procedure code G0434-QW represents a laboratory service with reimbursement determined per §134.203(e). The fee listed for this code in the Medicare Clinical Fee Schedule is \$15.13. 125% of this amount is \$18.91.

3. The total allowable reimbursement for the services in dispute is \$43.91. The insurance carrier has submitted documentation to support payment of this amount, plus an additional payment of \$7.05 interest, for a total of \$50.96, leaving an amount due to the requestor of \$0.00. No additional reimbursement is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that any additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 9, 2018
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.