



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

Consultants in Pain Medicine, PA

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-0634-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Firstly, the 28 TAC Rule 133.210 does not include lab services are requiring medical documentation to be submitted with the CMS-1500 forms. Besides, the laboratory report submitted with our appeal did support all services billed. Furthermore, Texas Mutual did not identify what information was lacking or missing for our claim to be adjudicated. Secondly, the 28 TAC Rule 134.20 Medical Fee Guidelines for Professional, established the claim Medicare payment policies for coding, billing report and reimbursement, but Texas Mutual utilized the Official Disability Guidelines to determine reimbursement. Additionally, Texas Mutual did not follow the CMS Correct Coding Initiatives for CPT code 82570 as they denied this code as included in another service.

Amount in Dispute: \$309.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No payment is due for code 82570. In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the remainder of the disputed codes."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2015	82570, 81003, G6041, G6056, G6045, G6046, G6031, G6051	\$309.71	\$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.

2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §137.100 sets out treatment guidelines for workers compensation services.
4. Texas Insurance Code Sec. 1305.153 sets out out-of-network provider reimbursement.
5. Texas Insurance Code Sec. 1305.006 sets out the liability of insurance carriers for out-of-network healthcare.
6. 28 Texas Administrative Code §133.210 sets out the documents required to be filed with medical bills during the medical billing process.
7. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - A05 – Service exceeds recommendations of treatment guidelines (ODG)
 - B5 – Coverage/program guidelines were not met or were exceeded
 - P12 – Workers' compensation jurisdiction fee schedule adjustment
 - 16 – Claim/service lacks information or has submission/billing error(s)
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 225 – The submitted documentation does not support the service being billed, we will re-evaluate this upon receipt of clarifying information
 - 725 – Approved non network provider for Texas Star Network claimant per rule 1305.153(c)
 - 193 – Original payment decision is being maintained
 - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
 - 724 – No additional payment after a reconsideration of services
 - 217 – The value of the procedure is included in the value of another procedure performed on this date

Issues

1. Were the services approved for an out of network provider?
2. Were the services in dispute recommended under the division's treatment guidelines?
3. Did the requestor meet division documentation requirements?
4. Did the carrier appropriately request additional documentation?
5. Were Medicare policies met?
6. Is reimbursement due?

Findings

1. The insurance carrier included remark code 725 – “Approved non network provider for Texas Star Network claimant per rule 1305.153(c). Texas Insurance Code, Sec. §1305.153 (c) states, “Out-of-network providers who provide care as described by Section [1305.006](#) shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.” The services in dispute will be reviewed per applicable rules and fee guidelines.
2. The carrier denied the disputed services as A05 – “Service exceeds recommendations of treatment guidelines (ODG).” 28 Texas Administrative Code (TAC) §137.100 (a) states in pertinent part, that “Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp...*” Review of the July, 2015 ODG pain chapter under the “Drug testing” and “procedure description finds that drug testing is “Recommended as an option...” Furthermore, ODG refers to procedure description “Urine Drug Testing (UDT)” where UDTs are described as “Recommended as a tool to monitor adherence to use of controlled substance treatment, to identify misuse (both before and during treatment), and as an adjunct to self-report of drug use.” The division concludes that the services were provided in accordance with the division's treatment guidelines; that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).
3. The carrier denied payment, in part, with claim adjustment code 225 citing that the documentation does not support the service billed, and that the carrier would “...re-evaluate this upon receipt of clarifying

information.” Similarly, in its response to this medical fee dispute, the carrier cites the lack of clarifying information and/or documentation as a reason for denial of payment. The process for a carrier’s request of documentation not otherwise required by 28 TAC 133.210 is detailed in section (d) of that section as follows: “Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.”

No documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

4. Health care provided in accordance with the ODG is presumed reasonable as specified in (c) of Rule §137.100. Section (e) of that same rule allows for the insurance carrier to retrospectively review reasonableness and medical necessity:

“An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.”

28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers’ compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as “A form of utilization review for health care services that have been provided to an injured employee.” No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity.

5. 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 82570 defined by the AMA CPT Code book as “Creatinine; other source.”

The CMS 2015, National Correct Coding Initiative Policy Manual, Chapter 10, Page X-7, Section E. titled , “Drug Testing” <https://www.cms.gov> states, “Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.” The carrier denied the disputed service as 217 – “The value of this procedure is included in the value of another procedure performed on this date.” The carrier’s denial is supported. No additional payment can be recommended.

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 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 2015 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:

81003 – Allowable $\$3.06 \times 125\% = \$ 3.83$
G6041 – Allowable $\$40.85 \times 125\% = \51.06
G6056 – Allowable $\$26.48 \times 125\% = \$33.10 \times 2 \text{ units} = \66.20
G6045 – Allowable $\$28.10 \times 125\% = \35.13
G6046 – Allowable $\$34.98 \times 125\% = \43.73
G6031 – Allowable $\$25.17 \times 125\% = \31.46
G6051 – Allowable $\$26.94 \times 125\% = \33.68

The total allowable for the services in dispute is \$231.99. This amount is recommended.

7. The total recommended payment for the services in dispute is \$231.99. The carrier made a payment of \$295.49 on November 24, 2015. 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

Medical Fee Dispute Resolution Officer

December , 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.