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

Respondent Name
Travelers Indemnity Co of Connecticut

MFDR Tracking Number
M4-16-1105-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We content that Travelers Insurance did not apply the 28 Texas Administrative Code Rules and Guidelines when auditing the laboratory services."

Amount in Dispute: $259.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Provider has failed to comply with the Medicare edits regarding required documentation as directed by Chapter 133. Consequently, the Provider is not entitled to reimbursement for the services in dispute."

Response Submitted by: Travelers Indemnity Co of Connecticut

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2015 May 21, 2015	82570, 81003, G6041, G6056, G6045, G6046, G6031 G6051	$259. 16	$231.99

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 requirements for filing a medical fee dispute.
2. 28 Texas Administrative Code §133.210 sets out the documents required to be filed with medical bills during the medical billing process.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement for clinical laboratory services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W3 – Additional payment made on appeal/reconsideration
   - 97 – Allowance included in another service

Issues

1. Is the requestor's position statement supported?
2. Were Medicare policies met?
3. Is reimbursement due?

Findings

1. In its response to this medical fee dispute, the carrier states "the Provider has not submitted a copy of the order requesting the urine drug screen as required by the Medicare edits, and did not do so in the bill submission either. 28 Texas Administrative Code §133.210 (c) states in pertinent part,

> In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
>
> > (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;
> >
> > (2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;
> >
> > (3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;
> >
> > (4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and
> >
> > (5) for hospital services: an itemized statement of charges.

The services in dispute are for clinical laboratory charges. Review of the above finds these are not services that require submission of supporting documentation per Division Guidelines.

28 TAC §134.203(7) states,

> Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

As the Division of Workers' Compensation (Division) rules do not require submission of supporting documentation, the respondent's position statement is not supported.

2. 28 TAC §134.203(b) states 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 initiative (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." 28 TAC §134.203(a) states that "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, values and weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." The services in dispute are clinical laboratory services; therefore, Medicare policies for the clinical laboratory services must be met. The services in

dispute are addressed in the CMS Clinical Laboratory Fee Schedule. The requestor billed the following AMA CPT codes/descriptions as follows:

- 82570 Creatinine; other source
- 81003 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
- G6041 Alkaloids, urine, quantitative
- G6056 Opiate(s), drug and metabolites, each procedure
- G6045 Assay of dihydrocodeinone
- G6046 Assay of dihydromorphinone
- G6031 Assay of benzodiazepines
- G6051 Assay of flurazepam (DWC60 shows date of May 21, 2015. Claim and EOB show 4/13/2015. This date will be reviewed)

Review of the medical bill finds that current AMA CPT Codes were billed, and however a CCI conflicts exists for 82570. Per National Correct Coding Initiative Edits Manual, Chapter X - Pathology and Laboratory Services (CPT Codes 80000 - 89999) E. Drug Testing which 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.*

Medicare billing exclusions do apply to the clinical laboratory service billed as 82570. The carrier's denial as 97 – "Allowance included in another service is supported". For this service in dispute the carrier's denial is supported. The remaining services in dispute will be reviewed per applicable rules and fee guidelines.

3. 28 TAC §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:

Date of Service	Submitted Code	Submitted Charge	Units	MAR
April 13, 2015	82570	$40.00	1	Excluded per NCCI edits
April 13, 2015	81003	$40.00	1	$3.06 x 125% = $3.83
April 13, 2015	G6041	$45.00	1	$40.85 x 125% = $51.06
April 13, 2015	G6056	$135.00	1	$26.48 x 125% = $33.10
April 13, 2015	G6045	$45.00	1	$28.10 x 125% = $35.13
April 13, 2015	G6046	$45.00	1	$34.98 x 125% = $43.73

April 13, 2015	G6031	$180.00	1	$25.17 x 125% = $31.46
April 13, 2015	G6051	$45.00	1	$26.94 x 125% = $33.68
			Total	$231.99

The total maximum allowable reimbursement for the services in dispute is $231.99. The amount previously paid by the Carrier is $0.00. The requestor is due $231.99.

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 $231.99.

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 $231.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January , 2016
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.