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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CONSULTANTS IN PAIN MEDICINE

Respondent Name
VIA METROPOLITAN TRANSIT

MFDR Tracking Number
M4-16-1948-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
MARCH 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $217.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider did not submit a position statement and has not included all CPT codes originally billed for DOS 08/06/2015, or all of the EOB's for DOS 08/06/2015 on the DWC60. According to our records we have not received a bill from this provider for this claim for DOS 04/13/2015. Since the provider has not submitted a clear position statement or indicated the correct DOS on the table of disputed services, Argus will stand on the original denial that the testing appears routine and not random and the medical records do not justify frequent drug testing. No additional reimbursement is recommended."

Response Submitted by: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2015	HCPCS Code G0431 Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening	$74.91	$0.00
August 6, 2015	HCPCS Code 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	$4.87	$0.00
April 13, 2015	HCPCS Code G6041 Alkaloids, urine, quantitative	$40.85	$0.00
April 13, 2015	HCPCS Code G6056 Opiate(s), drug and metabolites, each procedure	$26.48	$0.00
April 13, 2015	HCPCS Code G6045	$28.10	$0.00

	Assay of dihydrocodeinone		
April 13, 2015	HCPCS Code G6046 Assay of dihydromorphinone	$34.98	$0.00
April 13, 2015	HCPCS Code 82570 Creatinine; other source	$7.04	$0.00
TOTAL		$217.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.250 sets out the medical bill auditing and processing procedure.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 151D-Payment adjusted because the payer deems the information submitted does not support this level many/frequency of services. *Testing appears routine and not random.*
   - 151E-Payment adjusted because the payer deems the information submitted does not support this level many/frequency of services. *Medical records do not justify frequent drug testing.*
   - W3E-Duplicate reconsideration/appeal. An appeal of the original audit was previously performed for these services.
   - W3W-No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.
   - P12A-Workers compensation jurisdictional fee schedule adjustment. *Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.
   - W7-Payment of interest/penalty to provider.

Issues

1. Is date of service April 13, 2015 eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.307?
2. Does the documentation support billed service?

Findings

1. The respondent states in the position summary that "According to our records we have not received a bill from this provider for this claim for DOS 04/13/2015."

   28 Texas Administrative Code §133.307(c)(2)(J) sates, "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)." Review of the submitted documentation finds that the requestor did not submit copies of any medical bill(s) for date of service April 13, 2015 as originally submitted to the carrier and/or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

   28 Texas Administrative Code §133.307(c)(2)(K) states, "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for date of service April 13, 2015. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).

28 Texas Administrative Code §133.307(c)(2)(M) states, "a copy of all applicable medical records related to the dates of service in dispute." A review of the submitted documentation finds that the requestor did not submit a copy of medical records for April 13, 2015. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(M).

28 Texas Administrative Code §133.307(c)(2)(N) states, "a position statement of the disputed issue(s)." review of the submitted documentation finds that the requestor did not submit a position summary for April 13, 2015. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N).

28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)." A review of the submitted documentation finds no evidence that the requestor submitted the bills for date of service April 13, 2015 to the respondent prior to seeking medical fee dispute resolution.

The Division finds that date of service April 13, 2015 is not eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.250(i) and §133.307. As a result, reimbursement is not recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for codes G0431 and 81003 rendered on August 6, 2015 based upon reason codes "151D," and "151E."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or 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."

   A review of the submitted report finds that the requestor did not support billing codes G0431 and 81003; therefore, the respondent's denial based upon reason codes "151D," and "151E." As a result, reimbursement is not 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	04/15/2016 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, effective May 31, 2012, *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 MDR 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.