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
ANDREW BRYLOWSKI, MD

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-18-1609-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please allow this letter to serve as a request for reconsideration for the Designated Doctor component examination regarding the above-mentioned claimant…The diagnosis codes used for this claim are the following: 1. Orbital fracture…2. Nasal fracture…These diagnoses are accepted as the compensable injury according to the DWC 32 dated March 8, 2017."

Amount in Dispute: $2,281.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The first ICD-10 diagnosis code was changed from [redacted]. As noted in the carrier's initial response, we are going to reprocess the medical bill in light of Dr. Brylowski's amended CMS-1500. Once the bill is reprocessed, we will forward it to your attention and to that of Dr. Brylowski."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2017	CPT Code 96118 (X15) Neuropsychological Testing	$2,262.15	$2,262.15
	CPT Code 80305-QW Urinary Drug Test	$19.55	$0.00
TOTAL		$2,281.70	$2,262.15

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, effective May 31, 2017 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.10 effective September 1, 2012 sets out the Designated Doctor procedures and requirements.

3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
6. The services in dispute were reduced / denied by the respondent with the following reason code:
    - 146-Diagnosis was invalid for the date(s) of service reported.
    - W3-Request for reconsideration.
    - 193-Original payment decision is being maintained. Upon review it was determined that tis claim was processed properly.

Issues

1. Is the respondent's denial of payment supported?
2. Is the requestor entitled to reimbursement for codes 96118 and 80305-QW?

Findings

1. The requestor is seeking dispute resolution for codes 96118 and 80305-QW that were denied reimbursement based upon reason code "146-Diagnosis was invalid for the date(s) of service reported." The respondent wrote, "The first ICD-10 diagnosis code was changed from [redacted]. As noted in the carrier's initial response, we are going to reprocess the medical bill in light of Dr. Brylowski's amended CMS-1500."

   The requestor contends that payment is due because this was **"**The diagnosis codes used for this claim are the following: 1. Orbital fracture…2. Nasal fracture…These diagnoses are accepted as the compensable injury according to the DWC 32 dated March 8, 2017."

   28 Texas Administrative Code §127.10(c) states in part, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

   The division finds the respondent's denial based upon reason code "146" is not supported.

2. The applicable fee guideline for the disputed services is found in 28 Texas Administrative Code §134.203.

   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."

   28 Texas Administrative Code §134.203 (b)(1) states, "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."

   On the disputed date of service the requestor billed CPT code 96118 and 80305-QW. The description for these codes are:

   CPT code 96118 - "Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report."

   CPT code 80305- "Drug test(s), presumptive, any number of drug classes, any number of devices or

procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service."

Modifier QW-" CLIA waived test".

96118:

A review of the submitted report supports the 15 hours billed of code 96118; therefore, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(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 following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75234, which is located in Dallas, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

The 2017 DWC conversion factor for this service is 57.5.

The 2017 Medicare Conversion Factor is 35.8887

The Medicare participating amount for this location is $99.47.

Using the above formula the division finds the MAR is $159.37 X 15 hours = $2,390.55 or less. The requestor is seeking a lesser amount of $2,262.15. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $2,262.15.

80305-QW:

28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) states the request for dispute resolution shall include: " (O)

documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $19.55 for code 80305-QW would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $2,262.15.

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 $2,262.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/2/2018 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.