



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

DR SAM FINO

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-12-2706-01

Carrier's Austin Representative Box

Box Number 54

MFDR Date Received

April 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual is very inconsistent in their payment of the G0431 code. We are Clia waived and do not need a modifier and we are licensed with a Clia number 45D1100319. They have paid from \$40 to \$141 for this same code...We are asking for the remainder of the payment."

Amount in Dispute: \$160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute for the urine drug screen testing for disputed date 5/4/11. The requestor billed five units of code G0431. G0431 is a multipanel, qualitative drug screen test. Medicare indicates the code is to be reported only once per patient encounter. (Attachment) The requestor reported it five times. Texas Mutual paid one unit of the test."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2011	Urine Drug Screen	\$160.00	\$57.75

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1 Workers compensation state fee schedule adjustment.
 - CAC-16 Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code)
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 758 – ODG documentation requirements for urine drug testing have not been met.

- CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-4 The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 732- Accurate coding is essential for reimbursement. Modifier billed incorrectly. Services are not reimbursable as billed.
- 891- No additional payment after reconsideration.
- CAC-29 The time limit for filing has expired.
- 731- Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date the service. For services on or after 9/1/05.

Issues

1. Were Medicare policies met?
2. Is reimbursement due?

Findings

1. 28 TAC §134.203(b)(1) 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.” §134.203(a)(5) 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:

- CPT code G0431 , 5 units (analytes not elsewhere specified) liquid chromatography/mass spectrometry (LC/MS) quantitative;

Review of the medical bill finds that current AMA CPT Code billed, and that there are no CCI conflicts, Medicare billing exclusions, or medically unlikely edits (MUE) that apply to the clinical laboratory services in dispute. The requestor met 28 Texas Administrative Code §134.203.

2. The services in dispute are eligible for payment. 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 2011 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov>. Review of the document finds that the provider sufficiently documented the units billed. Therefore, the total MAR is \$97.75 as follows:

- G0431 5 Units billed/1 Unit payable = $(\$78.20 \times 1.25\%) \times 1 = \underline{\$97.75}$
\$97.75

The total amount calculated for payment is \$97.75. Requestor received payment in the amount of \$40.00; therefore the amount recommended for payment is \$57.75.

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 \$57.75.

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 \$57.75 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	Date
		April 30, 2014

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.