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 and Address

CHOICE LABORATORY SERVICE, LLC
PO BOX 674131
DALLAS TX 75267

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-12-1033-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The ODG recommends that verification of test results should occur with a different screening test or additional confirmatory tests to confirm results to avoid adverse consequences, such as false positives or false negative tests, however, the ODG does not specify the number of confirmatory tests that would be appropriate."

Amount in Dispute: $388.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue in this dispute is that the pain management doctor did not substantiate with his documentation the ODG risk stratification of the claimant's current clinical status…No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2011	Urine Drug Screen	$388.53	$388.54

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. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §133.210 sets out documentation requirements
3. 28 Texas Administrative Code §137.100 sets out treatment gudielines
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-B22 This payment is adjusted based on the diagnosis.
- 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)
- CAC-97 The benefit for this service is included in the payment/allowance for another service/procedure thqt has already been adjudicated.
- 217– The value of this procedure is included in the value of another procedure performed in this date.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 641– The medically unlikely edits (MUE) from CMS has been applied to this procedure code.
- 758 – ODG documentation requirements for urine drug testing have not been met.
- 907– Only treatment rendered for the compensable is reimbursable. Not all conditions are related to the compensable injury.
- CAC–18 Duplicate claim/service.
- 224– duplicate charge.

Issues

1. Did the requestor meet division documentation requirements?
2. Did the carrier appropriately request additional documentation?
3. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
4. Were Medicare policies met?
5. Is reimbursement due?

Findings

1. The workers' compensation carrier (carrier) denied services, in part, using claim adjustment code 758 which states that "ODG documentation requirements for urine drug testing have not been met." In its written response to this dispute, the carrier furthermore states that "did not substantiate with his documentation the ODG risk stratification." Documentation requirements for the services provided are not established by ODG, rather, documentation requirements are established by 28 TAC §133.210 which describes the documentation required to be submitted with a medical bill. 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute. The carrier's denial reason is not supported.

2. 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 described 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 with the specificity required by §133.210(d). The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

3. The carrier, in its response to this medical fee dispute, makes assertions that question the appropriateness of

the disputed care/services. For example, the insurance carrier asserts "…the testing is outside the requirements of ODG." Although the carrier's assertions are made based on language taken from the ODG, the issues raised in the carrier's response to medical fee dispute resolution indicate that the carrier may be asserting denial of payment based on an exsiting, unresolved issue of medical necessity. No documentation was found that demonstrates the existence of an unresolved issue of medical necessity, prior to the date the request for medical fee dispute resolution was filed.

Furthermore, the division notes that 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

> "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."

Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary." 28 TAC §19.2015(b) titled *Retrospective Review of Medical Necessity* states:

> (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute.

4. 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, ten units Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
   - CPT code 82570, one unit Creatinine; other source
   - CPT code 80102, eight units Drug confirmation, each procedure
   - CPT code 83789, three units Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen

   Review of the medical bill finds that current AMA CPT codes were 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 TAC §134.203.

5. 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 $388.54 as follows:

- G0431 10 Units billed/1 payable = ($78.20 x 1.25%) x 1 = $97.75
- 82570 1 Unit = ($7.28 x 1.25%) x 1 = $ 9.10
- 80102 8 Units = ($18.64 x 1.25%) x 8 = $186.40
- 83789 3 Units = ($25.41 x 1.25%) x 3 = $95.29

$388.54

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 $388.54.

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 $388.54 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	March 12, 2014 Date

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.