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
ADVANCED TOXICOLOGY

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-0392-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
September 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…each of these CPT codes although identical represent different drugs our lab is screening for and hence are NEITHER duplicates NOR multiples, NOR inaccurate."

Amount in Dispute: $1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed 12 units of code 80101 for a urine drug screen on the date above then billed Texas Mutual for this. Texas Mutual declined to issue payment of the billing absent correct coding. Medicare ceased paying urine drug screens coded with 80101 beginning 7/1/2010."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2013	Urine Drug Screen	$1,500.00	$0

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 §134.203 sets out the reimbursement guidelines for clinical laboratory services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - CAC-W1- Workers compensation state fee schedule adjustment.
   - 714- Accurate coding is essential for reimbursement. CPT/HCPS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
   - CAC-193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724-No additional payment after a reconsideration of services. For information call 1-800-937-6824.

Issues

1. Did the requestor appropriately bill the service rendered?
2. Were Medicare policies met?

Findings

1. The workers' compensation carrier (carrier) denied services, in part, using claim adjustment code 714- which states that "Accurate coding is essential for reimbursement. CPT/HCPS billed incorrectly. Corrections must be submitted w/I 95 days from DOS." Texas Administrative Code 134.203(b) (1) states, in pertinent part,"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;"

   The medical bill indicates that the requestor billed code 80101. The applicable Medicare policy for billing may be found in the Medicare Learning Network (MLN) Matters change request CR 6852 at http://www.cms.gov. Applicable section in CR 6852 indicates that "New test code G0431 is a direct replacement for CPT code 80101…effective dates of service on or after April 1, 2010, new test code G0431 should be utilized by those clinical laboratories that do not require a CLIA certificate of waiver…"

   Documentation supports that date of service billed is March 14, 2013. As stated per CR6852, dates of service billed after April 1, 2010 should be billed with new test code G0431. The division concludes that the requestor did not appropriately bill the service rendered. The respondent's denial of payment is supported.

2. 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:

   (1) CPT code 80101, twelve units drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter

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

		June 24, 2014
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, 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 d'ésta correspondencia, favor de llamar a 512-804-4812.