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
SERGIO ALVARADO MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2237-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
MARCH 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted the appeal to Texas Mutual, who denied it due to ODG documentation not submitted."

Amount in Dispute: $644.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue involves Texas Mutual's inability to make a medical necessity determination because of a lack of documentation. Texas Mutual's principal denials in this dispute pertained to the lack of information (documentation) provided. As such it constitutes a fee documentation denial, not a medical necessity denial."

Response Submitted by: Texas Mutual Insurance Company.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2013	Urine Drug Screen	$644.00	$370.76

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, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out documentation requirements
3. 28 Texas Administrative Code §137.100 sets out treatment guidelines
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 dated
   - 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.
- 891 – No additional payment after reconsideration.
- 217- The value of this procedure is included in the value of another procedure performed on this date.
- CAC-W3- In accordance with the TDI DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350- In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration or appeal.
- CAC-97- The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

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 "…to find what documentation is required is determined by looking elsewhere. In this case that is the ODG since the ODG is an adopted evidence-based guideline of the Division and addresses the service in dispute..." 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. 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 existing, 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 83789, two units of Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen
   - CPT code 80182, one unit of Nortriptyline
   - CPT code 80160, one unit of Desipramine
   - CPT code 82649, one unit of Dihydromorphinone
   - CPT code 82646, one unit of Dihydrocodeinone
   - CPT code 82520, one unit of Cocaine or metabolite
   - CPT code 83805, one unit of Meprobamate
   - CPT code 83840, one unit of Methadone
   - CPT code 82570, one unit of Creatinine; other source
   - CPT code 83986, one unit of pH; body fluid, not otherwise specified
   - CPT code 81003, one unit of Urinalysis, by dip stick or tablet reagent
   - CPT code 84311, one units of Spectrophotometry, analyte not elsewhere specified
   - CPT code 83925, four units of Opiate(s), drug and metabolites, each procedure
   - CPT code 82145, one unit of Amphetamine or methamphetamine
   - CPT code 80154, one unit of Benzodiazepines

   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 2013 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. Review of the documentation finds that the provider sufficiently documented units billed. Therefore, the total MAR is $370.76, as follows:

- 83789 2 Units billed/1 payable = ($24.82 x 1.25%) x 1 = $31.03
- 80182 1 Unit = ($18.63 x 1.25%) x 1 = $23.29
- 80160 1 Units = ($23.66 x 1.25%) x 1 = $29.58
- 82649 1 Unit = ($35.34 x 1.25%) x 1 = $ 44.18
- 82646 1 Unit = ($28.39 x 1.25%) x 1 = $35.49
- 82520 1 Unit = ($20.83 x 1.25%) x 1 = $ 26.04
- 83805 1 Unit = ($24.23x 1.25%) x 1 = $30.29
- 83840 1 Unit = ($22.45 x 1.25%) x 1 = $28.06
- 82570 1 Units = ($7.11 x 1.25%) x 1 = $8.89
- 83986 1 Unit = ($4.92 x 1.25%) x 1 = $ 6.15
- 81003 1 Unit = ($3.09 x 1.25%) x 1 = $3.86
- 84311 1 Units = ($9.61 x 1.25%) x 1 = $12.01
- 83925 4 Units billed/1 payable = ($26.74 x 1.25%) x 1 = $ 33.43
- 82145 1 Units = ($21.36x 1.25%) x 1 = $26.70
- 80154 1 Units = ($25.43 x 1.25%) x 1 = $31.79

$370.76

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 $370.76.

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 $370.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May , 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 de ésta correspondencia, favor de llamar a 512-804-4812.