



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Consultants in Pain Medicine

Respondent Name

City of San Antonio

MFDR Tracking Number

M4-15-2638-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We content that Tristar Risk Mgmt did not apply the 28 Texas Administrative Code Rules and Guidelines when auditing the laboratory services."

Amount in Dispute: \$293.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on April 28, 2015.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 5, 2014, Urinary Drug Screens, \$293.30, \$255.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the requirements for filing a medical fee dispute.
2. 28 Texas Administrative Code §133.210 sets out the documents required to be filed with medical bills during the medical billing process.
3. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.
4. 28 Texas Administrative Code §137.100 details concepts of disability management.
5. 28 Texas Administrative Code §134.203 sets out the reimbursement for clinical laboratory services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 151D - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. "Testing appears routine and not random."

- 151E – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. “Medical records do not justify frequent drug testing.”
- 18 – Duplicate claim/service
- 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services

The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### Issues

1. Were the services in dispute recommended under the division’s treatment guidelines?
2. Did the carrier appropriately raise reasonableness and medical necessity?
3. Were Medicare policies met?
4. Is reimbursement due?

### Findings

1. 28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, that “Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp...*” Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a). Review of the December 2014 ODG pain chapter under the “Drug testing” finds that drug testing is recommended. Furthermore, ODG refers to procedure description “Urine Drug Testing (UDT)” where UDTs are also described as “recommended.” The division concludes that the services were provided in accordance with the division’s treatment guidelines; that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).
2. The insurance carrier in its denials questions the appropriateness and medical necessity of the services in dispute. Health care provided in accordance with the ODG is presumed reasonable as specified in (c) of Rule §137.100. Section (e) of that same rule allows for the insurance carrier to retrospectively review reasonableness and medical necessity:

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.

28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers’ compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as “A form of utilization review for health care services that have been provided to an injured employee.” No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity.

3. 28 TAC §134.203(b) 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.” 28 TAC §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 – Drug Screen Multiple Class
- CPT Code – 82570 – Assay or urine; creatinine
- CPT Code – 82646 – Dihydrocodeinone
- CPT Code – 82649 - Dihydromorphinone
- CPT Code – 83925 – Opiate(s), drug and metabolites, each procedure
- CPT Code – 83986 - pH; body fluid, not otherwise specified

Review of the medical bill finds that current AMA CPT Codes were billed and no CCI conflicts or Medicare billing exclusions that apply to the clinical laboratory were found for the services in dispute. The requestor met 28 TAC §134.203(b).

4. 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 2014 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov>. The total MAR is calculated as follows:

Date of Service	Submitted Code	Submitted Charge	Units	MAR
December 5, 2014	G0431	\$400.00	1	\$75.82 x 1.25 = \$94.78
December 5, 2014	82570	40.00	1	\$7.06 x 125% = \$8.83
December 5, 2014	82646	45.00	1	\$28.17 x 125% = \$35.21
December 5, 2014	82649	45.00	1	\$35.07 x 125% = \$43.84
December 5, 2014	83925	90.00	2	\$26.54 x 125% = \$33.18 x 2 = \$66.36
December 5, 2014	83986	40.00	1	\$4.88 x 125% = \$6.10
	Total	\$660.00		\$255.12

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$255.12.

**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 \$255.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	<u>September 14, 2015</u>
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, 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 MFDR 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.**