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
Austin Pain Associates

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-2828-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…each line (drug) tested supports ODG guidelines. Per our office visit which is attached as well – this patient is a high risk patient."

Amount in Dispute: $1,815.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual had the right to retrospectively review the services."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2014	Urinary Drug Screens	$1,815.00	$703.69

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:

February 12, 2015

- 225 – The submitted documentation does not support the service being billed
- 758 – ODG documentation requirements for urine drug testing have not been met

April 24, 2015

- 225 – The submitted documentation does not support the service being billed
- 758 – ODG documentation requirements for urine drug testing have not been met
- 193 – Original payment decision is being maintained

Issues

1. Were the services in dispute recommended under the division's treatment guidelines?
2. Did the requestor meet division documentation requirements?
3. Did the carrier appropriately request additional documentation?
4. Did the carrier appropriately raise reasonableness and medical necessity?
5. Were Medicare policies met?
6. Is reimbursement due?

Findings

1. 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..."* Review of the December 2014 ODG pain chapter under the "Drug testing" and "procedure description" finds that drug testing is "Recommended as an option…" Furthermore, ODG refers to procedure description "Urine Drug Testing (UDT)" where UDTs are described as "Recommended as a tool to monitor adherence to use of controlled substance treatment, to identify misuse (both before and during treatment), and as an adjunct to self-report of drug use." 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 respondent's claim adjustment code 758 states that "ODG documentation requirements for urine drug testing have not been met." 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.

3. The carrier denied payment, in part, with claim adjustment code 225 citing that the documentation does not support the service billed, and that the carrier would "…re-evaluate this upon receipt of clarifying information." Similarly, 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 detailed 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."

The respondent included a certified letter dated February 11, 214 however; this document precedes the date of service and does not contain the required elements of Rule 133.210 (d). Therefore, no documentation was found to support that the carrier made an appropriate request for additional documentation during the billing process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

4. The insurance carrier in its response makes assertions that question the appropriateness and medical necessity of the services in dispute. Although these assertions are made based on language taken from the ODG, the issues raised indicate that the insurance carrier is denying payment based on medical necessity. For example, the insurance carrier asserts "Texas Mutual had the right to retrospectively review the services." 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 as required. 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.

5. 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, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
   - CPT code; 82542 - Column chromatography/mass spectrometry (eg, GC/MS, or HPLC/MS), non-drug analyte not elsewhere specified; quantitative, single stationary and mobile phase
   - CPT code 83805 – Meprobamate
   - CPT code 82646 – Dihydrocodeinone
   - CPT code 82649 – Dihydromorphinone

- CPT code 83925 – Opiate(s), drug and metabolites, each procedure

Review of the medical bill finds that current AMA CPT codes were billed, and that there are no CCI conflicts or Medicare billing exclusions that apply to the clinical laboratory services in dispute. The requestor included the -91 modifier on multiple claim lines. The CMS Medicare Claims Processing Manual, Chapter 16, Section 100.5.1 states in the pertinent part, "When it is necessary to obtain multiple results in the course of treatment, the modifiers 59 or 91 are used to indicate that a test was performed more than once on the same day for the same patient." The requestor met 28 TAC §134.203(b).

6. 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 30, 2014	G0431	$369.00	1	$75.82 x 125% = $94.78
December 30, 2014	82542	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542 -91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$84.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82542-91	$74.00	1	$24.63 x 125% = $30.79
December 30, 2014	82646	$74.00	1	$28.17 x 125% = $35.21
December 30, 2014	82649	$74.00	1	$35.07 x 125% = $43.84
December 30, 2014	83805	$74.00	1	$24.04 x 125% = $30.05
December 30, 2014	83925	$84.00	1	$26.54 x 125% = $33.18
December 30, 2014	83925 -91	$84.00	1	$26.54 x 125% = $33.18

December 30, 2014	83925 -91	$84.00	1	$26.54 x 125% = $33.18
	Total	$1,815.00		$703.69

The total maximum allowable reimbursement for the services in dispute is $703.69. The amount previously paid by the Carrier is $0.00. The requestor is due $703.69.

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 $703.69.

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 $703.69 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June 30, 2015
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.