



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

Sergio J. Alvarado MD

Respondent Name

City of San Antonio

MFDR Tracking Number

M4-15-3947-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 6, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We perform UDS on our patients as part of their on-going treatment and based on ODG guidelines for UDT drug monitoring on a random basis and not on a routine basis as they noted."

Amount in Dispute: \$644.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent submitted no position statement. 28 Texas Administrative Code §133.307(d) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." This dispute will be based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2014	Urinary Drug Screens	\$644.00	\$498.29

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

- 28 Texas Administrative Code §133.307 sets out the requirements for filing a medical fee dispute.
- 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 §134.203 sets out the reimbursement for clinical laboratory services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

October 20, 2014

- 161D – 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

November 26, 2014

- W3 – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule

July 17, 2015

- W3E – Duplicate reconsideration/appeal. An appeal of the original audit was previously performed for these services
- W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Worker's

Issues

1. Did the requestor meet division documentation requirements?
2. Did the carrier appropriately request additional documentation?
3. Did the carrier appropriately raise reasonableness and medical necessity?
4. Were Medicare policies met?
5. Is reimbursement due?

Findings

1. The carrier denied payment, in part, with claim adjustment code 151E citing that the submitted information does not support the service billed. 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."

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).

2. Per 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...*" Review of the August 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).

3. 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.

4. 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) 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 – 80154 Assay of benzodiazepines
- CPT Code – 81060 Assay of desipramine
- CPT Code – 80182 Assay of nortioptiline
- CPT Code – 81003 Urinalysis auto w/o scope
- CPT Code – 82145 Assay of amphetamines
- CPT Code – 82520 Assay of cocaine
- CPT Code – 82570 Assay of urine creatinine
- CPT Code – 82646 Assay of dihydrocodeinone
- CPT Code – 82649 Assay of dihydromorphinone
- CPT Code – 83789 Mass spectrometry quant
- CPT Code – 83805 Assay of meprobamate
- CPT Code – 83840 Assay of methadone

- CPT Code – 83925 Assay of opiates
- CPT Code – 83986 Assay ph body fluid nos
- CPT Code – 84311 Spectrophotometry

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 met 28 TAC §134.203(b).

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 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
August 28, 2014	83789	\$74.00	2	$\$24.63 \times 125\% = \30.79×2 units = \$61.58
August 28, 2014	80182	\$28.00	1	$\$18.49 \times 125\% = \23.11
August 28, 2014	80160	\$35.00	1	$\$23.48 \times 125\% = \29.35
August 28, 2014	82649	\$53.00	1	$\$35.07 \times 125\% = \43.84
August 28, 2014	82646	\$43.00	1	$\$28.17 \times 125\% = \35.21
August 28, 2014	82520	\$31.00	1	$\$20.68 \times 125\% = \25.85
August 28, 2014	83805	\$36.00	1	$\$24.04 \times 125\% = \30.05
August 28, 2014	83840	\$34.00	1	$\$22.28 \times 125\% = \27.85
August 28, 2014	82570	\$20.00	1	$\$7.06 \times 125\% = \8.83
August 28, 2014	83986	\$20.00	1	$\$4.88 \times 125\% = \6.10
August 28, 2014	81003	\$20.00	1	$\$3.06 \times 125\% = \3.83
August 28, 2014	84311	\$20.00	1	$\$9.54 \times 125\% = \11.93
August 28, 2014	83925	\$160.00	4	$\$26.54 \times 125\% = \$33.18 \times 4 =$ \$132.72
August 28, 2014	82145	\$32.00	1	$\$21.20 \times 125\% = \26.50
August 28, 2014	80154	\$38.00	1	$\$25.23 \times 125\% = \31.54
			Total	\$498.29

The total maximum allowable reimbursement for the services in dispute is \$498.29. The amount previously paid by the Carrier is \$0.00. The requestor is due \$498.29.

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 \$498.29.

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 \$498.29 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	December , 2015 Date
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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.