



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

Karasek, Dennis Edward

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-15-4050-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I also attached copies of the medical records, order form and lab results and authorization letter from Robert Nelson for review and to assist in reprocessing the claim only to get the claim denied three times."

Amount in Dispute: \$526.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the requestor's documentation does not support the billing of these codes consistent with the documented place of service, no payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2015	Urinary Drug Screens	\$526.00	\$328.24

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:

April 24, 2015

- A05 – Service exceeds recommendations of treatment guidelines (ODG)
- CAC – B5 - Coverage/program guidelines were not met or were exceeded
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed

June 1, 2015

- A05 – Service exceeds recommendations of treatment guidelines (ODG)
- CAC – B5 - Coverage/program guidelines were not met or were exceeded
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed
- 193 – Original payment decision is being maintained
- W3 – In accordance with TDI-DWC Rule 134.804, this bill, has been identified as a request for reconsideration or appeal

July 13, 2015

- A05 – Service exceeds recommendations of treatment guidelines (ODG)
- CAC – B5 - Coverage/program guidelines were not met or were exceeded
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 18 – Exact duplicate claim/service
- 225 – The submitted documentation does not support the service being billed
- 193 – Original payment decision is being maintained
- W3 – In accordance with TDI-DWC Rule 134.804, this bill, has been identified as a request for reconsideration or appeal

Issues

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

Findings

1. The carrier denied the disputed services as A95 – “Service exceeds recommendations of treatment guidelines (ODG) and CAC –B5 “Coverage/program guidelines were not met or were exceeded.” 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...*” 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 February, 2015 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 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.

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).

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. 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. The requestor states in their position statement, "Because the requestor's documentation does not support the billing of these codes consistent with the documented place of service, no payment is due."

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.

(F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

The respondents' statement was found to be a new defense not raised during the original adjudication or reconsideration of the claims in dispute. This position will not be considered in this review.

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 – G6031 Assay of benzodiazepines
- CPT Code – G6032 Assay of desipramine
- CPT Code – G6037 Assay of nortioptiline
- CPT Code – G6042 Assay of amphetamines
- CPT Code – G6044 Assay of cocaine
- CPT Code – G6045 Assay of dihydrocodenone
- CPT Code – G6046 Assay of dihydromorphinone
- CPT Code – G6052 Assay of meprobamate
- CPT Code – G6053 Assay of methadone
- CPT Code – G6056 Assay of opiates
- CPT Code – G6058 Drug confirmation

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 Division finds 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 2015 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
February 16, 2015	G6031	\$50.00	1	\$25.17 X 1.25 = \$31.46
February 16, 2015	G6032	\$47.00	1	\$23.42 X 1.25 = \$29.28
February 16, 2015	G6037	\$37.00	1	\$18.44 X 1.25 = \$23.05
February 16, 2015	G6042	\$42.00	1	\$21.15 X 1.25 = \$26.44
February 16, 2015	G6044	\$41.00	1	\$20.62 X 1.25 = \$25.78
February 16, 2015	G6045	\$56.00	1	\$28.10 X 1.25 = \$35.13
February 16, 2015	G6046	\$70.00	1	\$34.98 X 1.25 = \$43.73
February 16, 2015	G6052	\$50.00	1	\$23.98 X 1.25 = \$29.98
February 16, 2015	G6053	\$44.00	1	\$22.22 X 1.25 = \$27.78
February 16, 2015	G6056	\$53.00	1	\$26.48 X 1.25 = \$33.10
February 16, 2015	G6058	\$36.00	1	\$18.03 X 1.25 = \$22.54
	Total	\$526.00		\$328.24

The total maximum allowable reimbursement for the services in dispute is \$328.24. The amount previously paid by the Carrier is \$0.00. As a result, the amount ordered is \$328.24.

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 \$328.24.

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 \$328.24 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

September , 2015
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.