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
Compliance Toxicology

Respondent Name
Texas Municipal League Intergovernmental Risk Pool

MFDR Tracking Number
M4-16-0083-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Manzi's dictation states the UDT is 'medically necessary due to the patient taking controlled substances and requesting a medication refill today.'"

Amount in Dispute: $3974.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Note the extensive nature of the drug testing ordered by the provider. The only prescription medication at issue was Gabapentin. There was no history of drug abuse … The testing was not medically reasonable or necessary …"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2015	Urinary Drug Testing	$3974.85	$246.90

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 procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the documentation requirements for medical bills.
3. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization.
4. 28 Texas Administrative Code §137.100 sets out the Division's treatment guidelines.
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 462 – Service exceeds the Official Disability Guidelines (ODG) level of care

- 16 – Please submit letter of medical necessity from prescribing doctor.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Notes: Payment adjusted for absence of preauthorization
- Notes: Payment adjusted because the payer deems the information submitted does not support this level of service.
- W3 – Additional payment made on appeal/recon
- 193 – Original payment decision is being maintained
- Notes: No payment is being made on your 3rd submission. Previously paid for a drug screen to the treating doctor.

Issues

1. Is CPT code G0431 part of the disputed services?
2. Did the insurance carrier request additional documentation in accordance with 28 Texas Administrative Code §133.210?
3. Is the insurance carrier's denial for preauthorization supported?
4. Is the insurance carrier's denial for documentation supported?
5. What is the maximum allowable reimbursement (MAR) for the disputed services?
6. Is the requestor entitled to additional reimbursement?

Findings

1. CPT code G0431 was included on the Request for Medical Fee Dispute Resolution (DWC060). Per Explanation of Benefits dated June 24, 2015, the insurance carrier reimbursed this code at the full amount requested by the health care provider. Therefore, this code will not be considered for this dispute.

2. The insurance carrier included a request for further documentation in the explanation of benefits dated May 13, 2015, stating, "PLEASE SUBMIT LETTER OF MEDICAL NECESSITY FROM PRESCRIBING DOCTOR." Documentation requirements for medical bills are established by 28 Texas Administrative Code §133.210, which does not require documentation to be submitted with the medical bill for the services in dispute.

   The process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in subsection (d) 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 a request for additional documentation with the specificity required. For this reason, the Division concludes that carrier's request for additional documentation failed to meet the requirements of 28 Texas Administrative Code 133.210(d).

3. The insurance carrier denied disputed services, in part, with claim adjustment reason code 462 – "Service exceeds the Official Disability Guidelines (ODG) level of care;" and stating, "Payment adjusted for absence of preauthorization." 28 Texas Administrative Code §137.100(a) states,

   > Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title … or §137.300 of this title…

Review of 28 Texas Administrative Code §134.600 finds that clinical laboratory services do not require preauthorization. Therefore, the services in dispute are subject to 28 Texas Administrative Code §137.100.

28 Texas Administrative Code §137.100(c) states, "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)." Furthermore, 28 Texas Administrative Code §137.100(f) states that "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization…"

The service in dispute is a urine drug test. Review of the April 2015 edition of the ODG treatment guidelines finds that "Urine Drug Testing" is recommended. Because the service in dispute was provided in accordance with the division's treatment guidelines, preauthorization cannot be required. Therefore, the insurance carrier's denial is not supported.

4. The insurance carrier denied all services, in part, stating, "Payment adjusted because the payer deems the information submitted does not support this level of service." Procedure code 82542 is defined as "Column chromatography/mass spectrometry, non-drug analyte not elsewhere specified; quantitative, single stationary and mobile phase." Review of the submitted documentation does not support the performance of this test. Therefore, the insurance carrier's denial of procedure code 82542 for this reason is supported.

   Procedure code 84311 is defined as "Spectrophotometry, analyte not elsewhere specified." Review of the submitted documentation does not support the performance of this test. Therefore, the insurance carrier's denial procedure code 84311 for this reason is supported.

   Submitted documentation supports the performance of all other procedures included in this dispute. A detailed analysis of these codes follows.

5. 28 Texas Administrative Code §134.203 (b) states,

   > 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 initiatives (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 Texas Administrative Code §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.

   The Division finds that the services in dispute are not addressed in 28 Texas Administrative Code §134.203 (c)(1).

   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.

   G6042 – Assay of amphetamine or methamphetamine: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

G6031 – Assay of benzodiazepines: This CPT code is defined as the benzodiazepines class of drugs and does not indicate separate payment for individual drugs within the class. Therefore, 1 unit is allowed for this code. The MAR is calculated as follows:

Medicare CLFS	134.203 (e)(1)	Units	Total MAR
$25.17	$31.47	1	$31.47

G6044 – Assay of cocaine or metabolite: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

G6056-59 – Opiate(s), drug and metabolites, each procedure: The requestor is seeking reimbursement for 5 units. The Division finds that the health care provider tested for 6 opiates/metabolites that were not included in the testing under CPT code G0431. The MAR is calculated as follows:

Medicare CLFS	134.203 (e)(1)	Units	Total MAR
$26.48	$33.10	5	$165.50

G6053 – Assay of methadone: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

G6045 – Assay of dihydrocodeinone: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

G6046 – Assay of dihydromorphinone: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

G6052 – Assay of meprobamate: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

83992 – Assay for phencyclidine: Per Medicare's *Clinical Laboratory Fee Schedule (CLFS) Final Determinations* for 2015, this drug class is included in the testing under CPT code G0431. *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" Therefore, this code is not separately payable when billed with CPT code G0431.

G6056-59 – Opiate(s), drug and metabolites, each procedure: *Medicare Claims Processing Manual 100-4,* Chapter 16, 100.5.1 states,

> 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 91 modifier is used for laboratory tests paid under the clinical laboratory fee schedule.

The Division finds that modifier 59 was not supported for this code.

80637 – propoxyphene: This code has status of I – not valid for Medicare purposes.

80360 – methylphenidate: This code has status of I – not valid for Medicare purposes.

80371-59 – stimulants, synthetic: This code has status of I – not valid for Medicare purposes.

G6031 – Assay of benzodiazepines: *Medicare Claims Processing Manual 100-4,* Chapter 16, 90.3, 1. states, "Deny duplicate services detected within the same processing cycle …" This is the second billing for the same code for this date of service. Therefore, this service is not separately payable.

G6030 – Assay of amitriptyline: The requestor is seeking reimbursement for 1 unit. The MAR is calculated as follows:

Medicare CLFS	134.203 (e)(1)	Units	Total MAR
$24.36	$30.45	1	$30.45

80184 – Phenobarbital: The requestor is seeking reimbursement for 1 unit. The MAR is calculated as follows:

Medicare CLFS	134.203 (e)(1)	Units	Total MAR
$15.58	$19.48	1	$19.48

80304 – Drug screen, any number of drug classes, presumptive, single or multiple drug class method; not otherwise specified presumptive procedure, each procedure: This code has status of I – not valid for Medicare purposes.

80349 – Cannabinoids, natural: This code has status of I – not valid for Medicare purposes.

82570 – Creatinine, other source: The *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 10, E states,

> Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

Therefore, this code is not separately payable.

81003 – Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, uroblinogen, any number of these constituents; automated, without microscopy: The *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 10, E states,

> Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

Therefore, this code is not separately payable.

6. The total MAR for the disputed services is $246.90. On the explanation of benefits dated August 8, 2015, the insurance carrier stated that, "NO PAYMENT IS BEING MADE ON YOUR 3RD SUBMISSION. PREVIOUSLY PAID FOR A DRUG SCREEN TO THE TREATING DOCTOR." Review of the submitted documentation does not support that the services in question were previously paid by the insurance carrier. Therefore, a reimbursement of $246.90 is recommended.

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 $246.90.

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 $246.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 3, 2016
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.