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 Mutual Insurance

MFDR Tracking Number
M4-16-0439-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 19, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Compliance Toxicology LLC, rendered a urine drug test to the above reference claimant as ordered by the DWC treating physician. Texas Mutual denied the claim(s) based upon a veritable array of denial rationales including, "…do not meet ODG guidelines, lacks information, absence of precertification, documentation does not support, and services included in another procedure."

Amount in Dispute: $3,366.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted the billing a second time that Texas Mutual received 5/14/15. This second billing reflected significant change in the coding. Because this second bill with the change codes constituted a new bill Texas Mutual denied payment, absent timely filing, of the G codes with message code 731. Texas Mutual has elected to pay codes 83992, 82542, 83788, 80184, G0431, 81003 and 84311. The requestor billed G0431, 82570 and 83986. Both 82570 and 83986 are validity tests that are performed on the same specimen being tested with code G0431. Validity testing is an internal quality process to affirm the reported results are accurate and valid, and is not a separately billable Medicare service. (Texas Mutual has elected to pay G0431 code.) "

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2015	Urinary Drug Screen	$3,366.80	$0.00

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 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A04 – Denied in accordance with 134.600 (P)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 197 – Precertification/authorization/notification absent
   - 97 – The benefit for this services is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 225 – The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information
   - 18 – Exact duplicate claim/service
   - 29 – The time limit for filing has expired
   - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date of service
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Did the requestor meet division documentation requirements?
3. Was the corrected claim submitted timely?
4. Were Medicare policies met?
5. Is reimbursement due?

Findings

1. The requestor states in their position, "Texas Mutual denied the claim(s) based upon a veritable array of denial rationales including, "…do not meet ODG guidelines, lacks information, absence of precertification, documentation does not support, and services included in another procedure." Review of the submitted documentation finds codes 82145, 80154, 82520, 83925, 83840, 82646, 82649, 83805, 83992, 83925, 82542, 83789, 83788, 80154, 80152, 80184, G0431, 82652, 81003, and 84311 were denied for;
   - 16 – Claim/service lacks information or has submission/billing errors
   - A04 – Denied in accordance with 134.600 (P)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules
   - 197 – Precertification/authorization/notification absent
   - 225 – The submitted documentation does not support the service being billed

   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;

   The codes 82145, 80154, 82520, 83925, 83840, 82646, 82649, 83805, 83925, and 80154 were deleted as of

January 1, 2015. Therefore, the carrier's denial is supported for these codes.

Submitted codes 82570 and 83986 were denied as, 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated and 217 – "The value of this procedure is included in the value of another procedure performed on this date." As stated above Rule 134.203 (b) requires application of the correct coding initiatives (CCI) edits. Review of the 2015, National Correct Coding Initiative Policy Manual, Chapter 10, and the section "E" titled, "Drug Testing", "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 test to confirm that a urine specimen is not adulterated, this testing is not separately billed." The carriers' denial is supported.

Regarding the remark codes A04 and 197. 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). These denials were not maintained by the carrier and will not be considered in this review.

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. 28 Texas Administrative Code §133.20 (c) states,

   A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

   As stated above codes 82145, 80154, 82520, 83925, 83840, 82646, 82649, 83805, 83925, and 80154 were not in effect of the date of service in dispute. The carrier states, "The requestor submitted the billing a second time that Texas Mutual received 5/14/15. This second billing reflected significant change in the coding. Because this second bill with the change codes constituted a new bill Texas Mutual denied payment, absent timely filing, of the G codes with message code 731."

The carrier denied the disputed services upon reconsideration as 29 – "The time limit for filing has expired" and 731 – "Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date of service." 28 Texas Administrative Code 133.20(g) states, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." Review of the submitted documentation finds insufficient information to support the "new bill" with correct codes was submitted within requirements of Rule 133.20(g). The carrier's denial upon reconsideration is supported.

4. The remaining codes 83992, 82542, 83788, 80184, G0431, 81003 and 84311 are subject to 28 TAC §134.203(a)(5) which 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 – 80184 Assay of Phenobarbital
    - CPT Code 81003 – Urinalysis auto w/o scope
    - 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 – 83788 – Mass spectrometry qual
    - CPT Code – 83992 – Assay for phencyclidine
    - CPT Code – 84311 - Spectrophotometry
    - CPT Code – 83789 – Mass sopectormetry quant
    - CPT Code - G0431 Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter

    Review of the medical bill finds that current AMA CPT codes were billed. A CCI conflict exists between codes 83788 and 83789. The submitted medical claim contained no modifier or documentation to support separate reimbursement. With the one exception listed above, the requestor met 28 TAC §134.203(b) for these disputed codes.

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
February 2, 2015	83992	$216.80	2	$20.00 X 125% = $25.00 x 2 = $50.00
February 2, 2015	82542	$75.00	2	$24.58 x 125% = $30.73 x 2 = $61.46
February 2, 2015	83788	$75.00	1	CCI edits exists not

				separately payable
February 2, 2015	80184	$85.00	1	$15.58 x 125% = $19.48
February 2, 2015	G0431	$360.00	1	$75.63 x 125% = $94.54
February 2, 2015	81003	$35.00	1	$3.06 x 125% = $3.83
February 2, 2015	84311	$30.00	1	$9.52 x 125% = $11.90
February 2, 2015	83789	$85.00	1	$24.58 x 125% = $30.73
		Total		$271.94

The total maximum allowable reimbursement is $271.94. The carrier paid $271.94 on November 10, 2015. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November , 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.