



**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**

Consultants in Pain Medicine

**Respondent Name**

Travelers Indemnity Co of Conn

**MFDR Tracking Number**

M4-16-2278-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

April 5, 2016

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "All the required information was submitted for the lab testing that was performed as set forth by the Texas Administrative Code."

**Amount in Dispute:** \$249.55

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the maximum Allowable Reimbursement was properly calculated. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

**Response Submitted by:** The Travelers Companies

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2015	Urinary Drug Screens	\$249.55	\$249.55

**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 procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
  - 97 – Allowance included in another service.

- 16 – Claim/service lacks information which is needed for adjudication.
- 251 – The attachment / other documentation that was received was incomplete or deficient.

### Issues

1. Is the respondent's position supported?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

### Findings

1. The respondent states in their position statement, "The Provider's Table of Disputed Services reflects that the Carrier has not issued any reimbursement for the services at issue. This is clearly incorrect as the Explanation of Reimbursement in the Provider's Request for Medical Fee Dispute Resolution clearly show the Carrier issued reimbursement in the amount of \$137.80." The Division reviewed the Explanation of Benefits dated March 4, 2016 and found Proced-Mod G0431 was indicated as "Paid" in the amount of \$137.08. No other codes in dispute were paid. The requestor has not listed this code on DWC - 060. Therefore, the carrier's position as a payment made on the services in dispute is not supported.
2. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Allowance included in another service." 28 TAC §134.203(b)(1) 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." §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.

80171 – Drug Screen quant gabapentin

81003 – Urinalysis quto w/o scope

82570 – Assay of urine creatinine

G6031 – Assay of benzodiazepines

G6041 – Assy of urine alkaloids

G6045 – Assay of dihydrocodeinone

G6046 – Assay of dihydromorphinone

G6051 – Assay of flurzaepam

G6056 – Assay of opiates

Review of the medical bill finds that current AMA CPT Codes were billed. Per the National Correct Coding Initiative Policy Manual for Medicare Services, Chap10-Cptcodes 80000-89999, E. 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 tests to confirm that a urine specimen is not adulterated, this testing is not separately billed. The Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual,*

*Chapter 16 (Laboratory Services), Section 10 (Background) indicates that a laboratory test is a covered benefit only if the test result is utilized for management of the beneficiary's specific medical problem. Testing to confirm that a urine specimen is unadulterated is an internal control process that is not separately reportable.*

Based on the above code 82570 – (Assay of urine creatinine) is not separately payable. The requestor met 28 TAC §134.203. The carrier's denial for 83270 is upheld, the denial for the other submitted codes is not supported. These services will be reviewed per applicable rules and fee guidelines.

3. 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 maximum allowable reimbursement is calculated as follows:

Date of Service	Submitted Code	Allowable	MAR
May 4, 2015	80171	18.04	\$18.04 X 125% = \$22.55
May 4, 2015	81003	3.06	\$3.06 X 125% = \$3.82
May 4, 2015	G6031	25.17	\$25.17 X 125% = \$31.46
May 4, 2015	G6041	40.85	\$40.85 X 125% = \$51.06
May 4, 2015	G6045	28.10	\$28.10 X 125% = \$35.12
May 4, 2015	G6046	34.98	\$34.98 X 125% = \$43.72
May 4, 2015	G6051	26.94	\$26.94 X 125% = \$33.67
May 4, 2015	G6056	26.48	\$26.48 X 125% = \$33.10
		Total	\$254.50

4. The maximum allowable reimbursement for the services in dispute is \$254.50. The requestor is seeking \$249.55. This amount 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 \$249.55.

**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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$249.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	April 28, 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.**