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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-16-2978-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $159.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the requester billed code G0479 and G0480. Texas Mutual paid cod G0479. However, based on CMS' final 2016 determination Texas Mutual believes only one code, presumptive or definitive, may be billed per day but not both."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2016	G0479, G0480	$159.19	$79.51

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 §134.203 sets out the reimbursement for clinical laboratory services 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
- CAC – P12 – Workers' compensation jurisdictional fee schedule adjustment
- CAC – 16 Claim/service lacks information or has submission/billing error(s)
- CAC – 197 – Precertification/authorization/notification absent
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information

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 respondent's claim adjustment code 225– "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information. Documentation requirements for the services provided are not established by ODG, rather, documentation requirements are established by 28 TAC §133.210 which describes the documentation required to be submitted with a medical bill. 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute.
2. The carrier in its response to this medical fee dispute, 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. The insurance carrier in its response makes assertions that question the appropriateness and medical necessity of the services in dispute. Although these assertions are made based on language taken from the ODG, the issues raised indicate that the insurance carrier is denying payment based on medical necessity. The ODG, Pain, 2016, states, "*Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances*." 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:
    a. CPT Code – G0479 - Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service
    b. CPT Code - G0480 – Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed

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). The respondent states in their position statement, "Texas Mutual believes only one code, presumptive or definitive, may be billed per day but not both."

The applicable Medicare policy found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2016-CLFS-Codes-Final-Determinations.pdf states,

> Calendar Year (CY) 2016 Clinical Laboratory Fee Schedule (CLFS) Final Determinations
>
> A. Drug Testing
>
> Current coding for testing for drugs of abuse relies on a structure of "screening" (known as "presumptive" testing) followed by "confirmation" to confirm the results of the screening tests and quantitative or "definitive" testing that identifies the specific drug and quantity in the patient.
>
> After further consideration of public comments on this issue, we are implementing the following changes for drug testing for Calendar Year (CY) 2016:
>
> 1. Delete the following G-codes:
>   a. G0431, G0434
>   b. HCPCS codes G6030 through G6058
> 2. Continue to not recognize the AMA CPT codes 80300 – 80377

3. For presumptive testing, create three G codes. **Only one of the three presumptive G codes may be billed per day.**
4. For definitive testing, create four G codes. **Only one of the four definitive G codes may be billed per day.**
5. For definitive testing, the unit used to determine the appropriate definitive G code to bill is "drug class."
6. Each drug class may only be used once per day in determining the appropriate definitive G code to bill.

Review of the Correct Coding Initiatives find no edits between these two codes. The carrier's position is not supported.

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 2016 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
January 11, 2016	G0479	$400.00	1	$60.6 x 125% = $75.75
January 11, 2016	G0480	$315.00	1	$79.94 x 125% = $99.93
	Total	$715.00		$175.68

The total maximum allowable reimbursement for the services in dispute is $175.68. The amount previously paid by the Carrier is $96.17. The requestor is due $79.51.

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 $79.51.

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 $79.51 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	June 21, 2016 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.