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
Ved V Aggarwal MD

Respondent Name
Travelers Indemnity Co of Connecticut

MFDR Tracking Number
M4-16-3219-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
June 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All codes according to the 2015 Clinical Diagnostic Laboratory Services are payable, the services pertaining to the Labs being ordered is of "Pain Management Services" to "Detect any form of Drug Abuse/Monitor Medication" and Do Not have to have Authorization to render these type of services."

Amount in Dispute: $560.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to separate reimbursement for the individual drug screen panels. The Carrier has reviewed the Medicare coding edits applicable to urine drug screens and disagrees. The Carrier contends reimbursement for the individual panels is included in the reimbursement for the urine drug screen itself. Consequently, the Provider is not entitled to separate reimbursement."

Response Submitted by: Travelers Indemnity Co of Connecticut

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2015	Urinary Drug Screens	$560.20	$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 §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.203 (b) states in pertinent part,

> 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.

Review of the National Correct Coding Initiative Policy Manual found at www.cms.hhs.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, finds the following: Chapter 12, Section 12;

"*HCPCS code G0431 (drug screen … by high complexity test method…, per patient encounter is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only (1) unit of service regardless of the number of drugs screened."*

Based on the above the Carrier's denial is supported. No additional payment is due.

2. Pursuant to requirements of Rule 134.203(b) 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 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.