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

MFDR Tracking Number
M4-17-3147-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
June 26, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 80307 is a new code that replaced G0479. Note new code implemented on 01/01/17. Pleaser review notes requested and reprocess our claim. 2 different test one is screening the other is confirmation."

Amount in Dispute: $98.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0480 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2017	80307	$98.85	$76.28

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.
    1. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
    2. 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 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. What rule is applicable to fee calculation?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for Code 80307 – "Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service" in the amount of $98.85 for date of service March 27, 2017.

   The insurance carrier states in their position statement, "The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0480 reimbursed under this date of service."

   Review of the National Correct Coding Initiative Procedure-to-Procedure (PTP) from the Centers for Medicare and Medicaid services at www.cms.gov found no edits exit between codes G0481 and 80307.

   The NCCI Policy Manual, Chapter 10, Section E (Drug Testing) also at www.cms.gov states,

   > *Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.*
   >
   > *Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.*

   Therefore, the carrier's position is not supported as the services submitted on the medical bill are distinct in their description and no edits exist. The service in dispute will be reviewed per applicable fee guidelines.

2. The service in dispute is subject to the provisions of 28 Texas Administrative Code 134.203 (e) which states in relevant part,

   > 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.

   Review of the 2017 Clinical Diagnostic Laboratory Fee Schedule finds no separate reimbursement for the professional fee. The maximum allowable reimbursement calculation is Medicare Allowable x 125% or $61.02 x 125% = $76.28. This amount is recommended.

3. The total allowable for the service in dispute is $76.28. The carrier previously paid $0.00. The requestor is due a payment of $76.28.

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 $76.28

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $76.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 20, 2017
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 Rule §133.307, effective May 31, 2012, *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. **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.