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 PA

Respondent Name
AMERICAN ZURICH INSURANCE

MFDR Tracking Number
M4-19-0397-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim should be reimbursed according to the CMS Fee Schedule Laboratory CY 2018 and calculated at (Professional & Technical) percentage."

Amount in Dispute: $541.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The CPT codes in dispute are 80307 and G0483. The provider is seeking reimbursement of $541.86. The carrier previously reimbursed the provider for an outpatient visit. We are attaching a copy of EOBs dated June 12, 2018, June 26, 2018 and September 11, 2018. It is the carrier's position that the provider is not entitled to reimbursement for the disputed services."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2018	G0483 and 80307	$541.86	$393.62

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. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal

Issues

1. Was the requestor required to obtain preauthorization for the disputed services?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied HCPCS Code G0483 and CPT Code 80307 rendered on May 24, 2018 with denial reason codes "197 and W3" (explanations provided above.)

   28 Texas Administrative Code §134.600(p)(12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   HCPCS Code G0483 is defined as "Drug test(s), definitive, utilizing (1) 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)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed."

   CPT Code 80307 is defined as "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, LCMS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service."

   28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, "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 2018 ODG pain chapter under the "Drug testing" finds that drug testing is recommended. The division concludes that the services were provided in accordance with the division's treatment guidelines; and 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).

   For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the services in dispute.

2. The disputed services are clinical laboratory services and therefore subject to the provisions of 28 Texas Administrative Code §134.203 (e) which states in pertinent 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."

   Reimbursement is determined pursuant to Medicare's 2017 Clinical Laboratory Fee Schedule found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/ and calculated as follows:

   - Procedure code 80307, May 24, 2018, represents a lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $61.02. 125% of this amount is $76.28. Therefore, this amount is recommended.
   - Procedure code G0483, May 24, 2018, represents a lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $253.87. 125% of this amount is $317.34. Therefore, this amount is recommended.

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $393.62. Therefore, 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 $393.62.

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 $393.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 8, 2018
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.