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
SAMUEL ALIANELL MD

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-20-1026-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
December 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon appeal, the carrier denied the claim for workers' compensation medical treatment guidelines adjustment with a note that documentation does not support how monthly testing performed on this date of service is supported and/or recommended by ODG. All other services provided by this health care provider have been paid by the carrier, including the urine drug confirmation on this date of service."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office will maintain denial for charges in dispute for CARC code P15 as the medical records reviewed in this case do not provide sufficient evidence of how the testing performed on this date of service is supported by ODG for the medication management of the compensable injury."

Response Submitted by: SORM

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
June 18, 2019	80307	$300.00	$80.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §137.100 sets out the treatment guidelines for workers compensation services.
3. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
4. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation (TWC) system.
5. 28 TAC Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under TWC insurance coverage.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    1. Note: Documentation does not support how monthly testing performed on this date of service is supported and/or recommended by ODG
    2. P15 – Workers' Compensation medical treatment guideline adjustment
    3. W3 – Additional payment made on appeal/reconsideration

Issue(s)

1. What is the definition of CPT Code 80307?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 80307, clinical laboratory services rendered on June 18, 2019.

    28 TAC §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."

    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, GCMS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service."

2. The clinical laboratory services were denied by the insurance carrier with denial reduction code(s); "P15 – Workers' Compensation medical treatment guideline adjustment" and "Note: Documentation does not support how monthly testing performed on this date of service is supported and/or recommended by ODG."

    The insurance carrier in its response states, "… medical records reviewed in this case do not provide sufficient evidence of how the testing performed on this date of service is supported by ODG for the medication management of the compensable injury."

    28 TAC §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)."

    28 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 TLC §401.011(22-a).

    Review of the 2019 ODG pain chapter under the "Drug testing" finds that drug testing is recommended. The DWC concludes that the services were provided in accordance with the DWC's treatment guidelines; that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and TLC §413.017; and are also presumed to be health care reasonably required as defined by TLC §401.011(22-a).

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

3. Reimbursement is determined pursuant to Medicare's 2019 Clinical Laboratory Fee Schedule found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/ and calculated as follows:

   28 TAC §134.203 (e) 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.

   The maximum allowable reimbursement is calculated as follows:

   The 2019 Medicare Allowable Reimbursement (MAR) is $64.65 x 125% = $80.81. Therefore, this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to a MAR amount of $80.81.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $80.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $80.81 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 24, 2020
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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.