



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Ved Aggarwal, MD

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-21-2464-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

August 30, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 29, 2020	G0482	\$298.12	\$0.00
Total		\$298.12	\$0.00

Requestor's Position

The requestor did not include a position statement but did submit a copy of their reconsideration that states, "I would like to emphasize that for Pain Management Specialty Service, Laboratory Code NOT required to have Authorization prior to the services being rendered."

Amount in Dispute: \$298.12

Respondent's Position

Texas Mutual reviewed the billing and documentation from the provider for the dispute date noted above. The appeal was reviewed and confirmed G0482 was billed, per AMA/CPT coding guidelines this code is for 15-21 drug class(es). Documentation supports 11 drug classes screened... ..message modifier 892, 225 was noted on the EOB to notify the provider a more appropriate code is available for the drug class screening

Response Submitted by: Texas Mutual

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.202 sets out the billing requirements for professional medical services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information or has submission/billing error(s), which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 892 – Denied in accordance with DWC Rules and/or medical fee guidelines including current CPT code descriptions/instructions
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance Carrier's denial based on coding supported?

Findings

1. The requestor is seeking reimbursement of Code G0482 - "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; 15-21 drug class(es), including metabolite(s) if performed."

Review of the submitted "Screening Results" found eleven drug classes listed. The insurance carrier's denial is supported. No additional payment is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

_____	_____	October 19, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.