

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

VED V AGGARWAL MD PA

**Respondent Name**

TRUMBULL INSURANCE COMPANY

**MFDR Tracking Number**

M4-22-0003-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

September 1, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 26, 2021	80307 and G0481	\$396.36	\$273.42
	<b>Total</b>	\$396.36	\$273.42

### Requestor's Position

"Claim attached has denied for UDS Services, is is [sic] protocol to render these services at random to the patients for Pain Management, the last UDS was rendered back on 11/2020 and that was only for Confirmative 80307, for this Services both Confirmative and Definitive were both rendered and as you will see the Test Results it was necessary to render both at this time."

**Amount in Dispute:** \$396.36

### Respondent's Position

"Please accept this letter as a response to the above dispute. Bill was denied as not approved per adjuster: The Guidelines do not address the frequency of drug screens; hence, they are outside the Guidelines and require prior auth."

**Response Submitted by:** The Hartford

## 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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
4. 28 TAC §137.100 sets out the treatment guidelines.

### Denial Reasons

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

- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review.
- 293 – This procedure required prior authorization, and none was identified.
- Auth – Payment denied/reduced for absence of or exceeded pre-certification/authorization. Pre-authorization was not obtained, and treatment was rendered without the approval of treating doctor. If you require additional information regarding this bill decision, contact the claim handler.
- 06 – non-covered charge
- APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler.

### Issues

1. What is the definition of CPT codes G0481 and 80307?
2. Are the insurance carrier's denial reasons supported?
3. What is the rule that applies to reimbursement for clinical laboratory services?
4. Is the requestor entitled to reimbursement for CPT Codes G0481 and 80307?

## Findings

1. The requestor seeks medical fee dispute resolution for procedure codes 80307 and G0431.

28 TAC §134.203(b) states "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..."

Procedure Code G0481 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; 8-14 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 (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., 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 respondent denied reimbursement for code G0481 and 80307 based upon a lack of preauthorization.

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 2021 ODG Pain chapter under Drug testing finds that drug testing is recommended.

The DWC finds that the services were provided in accordance with the DWC's treatment guidelines; therefore, the insurance carrier's denial of reimbursement is not supported.

3. The fee guidelines for disputed service is found in 28 TAC §134.203.

Procedure codes G0481 and 80307 represent a lab service paid per Rule §134.203(e).

28 TAC §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 DWC 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 DWC established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

The 2021 Medicare Allowable Reimbursement (MAR) for G0481 is  $\$156.59 \times 125\% = \text{MAR } \$195.74$

The 2021 Medicare Allowable Reimbursement (MAR) for 80307 is  $\$62.14 \times 125\% = \text{MAR } \$77.68$

4. The DWC finds that the requestor is therefore entitled to reimbursement in the amount of \$273.42.

### 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 requestor has established that reimbursement of \$273.42 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$273.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 4, 2021  
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).