TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
CONFIRMATIVE MANAGEMENT SVC

Respondent Name
MARKEL INSURANCE COMPANY

MFDR Tracking Number
M4-22-2043-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
May 17, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 18, 2021	G0483 and 80307	$750.00	$386.32
	Total	$750.00	$386.32

Requestor's Position

"Review of the 2021 ODG Pain chapter under Drug testing finds that drug testing is recommended. Services provided are in accordance with the DWC's treatment guidelines; therefore, the insurance carrier's denial of reimbursement is not supported."

Amount in Dispute: $750.00

Respondent's Position

"Upon receipt of the medical bill from Confirmative Management Services, Markel Insurance Company appropriately denied the bill as the treatment provided was unrelated to the compensable injury."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

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, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system

Denial Reasons

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

- 107 - THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT IDENTIFIED ON THIS CLAIM.
- 350 - BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- C28 - DENIED: PER CARRIER, THIS TREATMENT IS NOT RELATED TO THIS WORKERS COMP CLAIM. CONTACT THE CLAIMANT FOR ALT COVERAGE INFORMATION.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 18 – EXACT DUPLICATE CLAIM/SERVICE
- 224 – DUPLICATE CHARGE
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Is the insurance carrier's denial reason supported?
2. What is the definition of HCPCS Code G0483 and CPT Code 80307?
3. Is the requestor entitled to reimbursement?

Findings

1. The services in dispute were denied by the workers' compensation carrier due to an unresolved extent of injury issue. 28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Review of the documentation submitted finds that the carrier did not provided documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by 28 TAC §133.307(d)(2)(H) or that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication pursuant to 28 TAC §133.307. For that reason, the dispute is eligible for review.

2. The requestor seeks reimbursement for HCPCS Code G0483 and 80307 rendered on August 18, 2021.

   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."

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

3. 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 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."

   Reimbursement is determined pursuant to Medicare's 2021 Clinical Laboratory Fee Schedule found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/ and calculated as follows:

Date of Service	CPT Code	Requested Amount	Medicare Clinical Lab Fee X 125%	MAR	Recommended Amount
8/18/21	80307	$150.00	$62.14 x 125% = $77.67	$77.67	$77.67
8/18/21	G0483	$600.00	$246.92 X 125% = $308.65	$308.65	$308.65
	TOTALS	$700.00	$386.32	$386.32	$386.32

Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of $386.32. Therefore, this amount is recommended.

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.

The DWC finds the requester has established that reimbursement of $386.32 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 $386.32 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 14, 2022
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 electronico CompConnection@tdi.texas.gov.