TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
CONFIRMATIVE MANAGEMENT SVC

Respondent Name
TPCIGA FOR AMERICAN MOTORISTS INSURANCE COMPANY

MFDR Tracking Number
M4-22-2124-01

Carrier's Austin Representative
Box Number 50

DWC Date Received
May 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 1, 2021 through March 7, 2022	G0483 x 3 and 80307 x 3	$2,050.00	$1,158.96
	Total	$2,050.00	$1,158.96

Requestor's Position

"28 Texas Administrative Code §134.600 (p)Non-emergency health care requiring preauthorization does not list urinary drug screens as services that require prior authorization. The insurance carrier's denial reason is not supported, we request immediate reimbursement for the services in dispute. UDS does not require prior authorization."

Amount in Dispute: $2,050.00

Respondent's Position

"Therefore, since these services exceeded treatment approved by the ODG and they are not part of a treatment plan approved by the insurance carrier, they require preauthorization. The denials applied to these services at the time of our review were for no preauthorization and also for being denied at Retrospective Utilization Review."

Response Submitted by: Flahive, Ogden & Latson

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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 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:

- 5040 -RETROSPECTIVE UTILIZATION REVIEW FINDINGS
- 197 -PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
- 216 -BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.

Issues

1. What is the definition of HCPCS Code G0483 and CPT Code 80307?
2. Did the disputed service require preauthorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS Code G0483 and 80307 rendered on December 1, 2021 through March 7, 2022.

   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."

2. The insurance carrier denied the disputed service with denial reason codes 5040, 197 and 216 (description provided above). The DWC will now determine whether the disputed service, HCPCS Code G0483 and CPT Code 80307 rendered on December 1, 2021 through March 7, 2022 required preauthorization pursuant to 28 TAC §134.600.

   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 and 2022 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; and the services are presumed reasonable pursuant to 28 TAC §137.100(c).

   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. The reimbursement guidelines for HCPCS Code G0483 and CPT Code 80307 is found at 28 TAC §134.203(e). 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
12/1/21	80307	$150.00	$62.14 x 125% = $77.67	$77.67	$77.67
12/1/21	G0483	$600.00	$246.92 X 125% = $308.65	$308.65	$308.65
2/7/21	80307	$150.00	$62.14 x 125% = $77.67	$77.67	$77.67
2/7/21	G0483	$600.00	$246.92 X 125% = $308.65	$308.65	$308.65
3/7/21	80307	$150.00	$62.14 x 125% = $77.67	$77.67	$77.67
3/7/21	G0483	$600.00	$246.92 X 125% = $308.65	$308.65	$308.65
	TOTALS	$2,050.00	$1,158.96	$1,158.96	$1,158.96

Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of $1,158.96. 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 $1,158.96 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 $1,158.96 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 8, 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.