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 Svcs, LLC

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-23-0317-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 7, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 13, 2021	G0483	$101.24	$101.24
November 24, 2021	G0483	$101.24	$101.24
	Total	$202.48	$202.48

Requestor's Position

We are requesting immediate payment of the above reference claim/services. Please review the attached supporting documentation which justifies our request to process this claim for final resolution.

Amount in Dispute: $202.48

Respondent's Position

The presumptive test showed two positives on date of service 10/13/2021: one for Acetaminophen; and one for Dextrorphan … There was only one positive for Acetaminophen on date of service 11/24/2021. All other drug classes were negative on both. Response allowed reimbursement for both dates of service for the 1-7 drug class testing.

Criteria to establish medical necessity for drug testing must be based on patient-specific

elements identified during the clinical assessment, documented by the clinician in the patients' medical record, and minimally include the following elements: patient history; physical examination; previous laboratory findings; current treatment plan; prescribed medication(s); and risk assessment plan. These required elements were not properly documented in the records.

In conclusion, Requestor is not owed additional reimbursement for the drug testing due to lack of proper documentation.

Response Submitted by: Downs-Stanford, P.C.

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 §133.240 sets out the procedures for payment and denial of medical bills.

2. 28 TAC §133.305 sets out the procedures for resolving medical disputes.

3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

4. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

5. 28 TAC, Chapter 19 sets out the requirements for utilization review.

Denial Reasons

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

- 96 – Non-covered charge(s).
- 960 – Services not medically appropriate or necessary.
- 5343 – Documentation submitted does not support the medical necessity for confirmatory testing of more than 7 drug classes. Reimbursement is for the appropriate supported code, G0480 and is being issued on the EOR or a previously processed EOR.
- 6575 – A test may be followed by confirmation with a second method, only if there is a positive or negative inconsistent finding from the qualitative/presumptive test in the setting of a symptomatic patient. In all cases, drug tests must be based on medical necessity and must be reasonable in the treatment of the patient's current treatment plan. Therefore, confirmatory testing is not warranted.
- 6606 – Medical necessity for the billed service is not substantiated by the medical notes. Drugs or drug classes for which screening is performed should only reflect

those likely to be present based on the patients medical history or current clinical presentation and without duplication. Each drug or drug class being tested for must be indicated, by the referring clinician, in a written order and so reflected in the patients medical record. Additionally, the clinicians documentation must be patient specific and accurately reflect the need for each test. Confirmatory testing is not appropriate for every specimen and should not be done routinely. This type of test should be performed in a setting of unexpected results and not on all specimens. The rationale for each confirmatory test must be supported by the ordering clinicians documentation. Claims for which the medical records do not meet documentation requirements will not be reimbursed.

- 6766 – Specialty bill audit/expert code review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's current Procedural Terminology (CPT) Manual, and coding guidelines developed by national societies and prevailing industry standards and coding practices.
- 295 – We cannot review this service without the report or invoice. Please submit the report or invoice as soon as possible to ensure an accurate processing.
- 6714 – Provider failed to submit drug screen results, bills for services or procedures shall be considered not properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. For reconsideration, please resubmit this bill with a copy of the quantitative/confirmatory drug screen results.
- 16 – Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2008 – Additional payment made on appeal/reconsideration.

Issues

1. Is this dispute subject to dismissal based on medical necessity?

2. Is the insurance carrier's reduction of payment based on lack of documentation supported?

3. Is the insurance carrier's reduction of payment using a different CPT code's value supported?

4. Is Confirmative Management Svcs, LLC entitled to additional reimbursement?

Findings

1. Confirmative Management Svcs, LLC is seeking reimbursement for laboratory testing performed on October 13, 2021, and November 24, 2021. The insurance carrier reduced the disputed services, in part, based on medical necessity.

   According to 28 TAC §133.305(b), medical necessity disputes must be resolved prior to

submission of a medical fee dispute. 28 TAC §133.240(q) requires the insurance carrier to perform a utilization review before a denial based on medical necessity, including giving the health care provider an opportunity to discuss the treatment in question.

When responding to a medical fee dispute, 28 TAC §133.307 (d)(2)(I) requires the respondent to submit documentation that supports a denial based on lack of medical necessity. Indemnity Insurance Co. of North America provided no evidence to support that it performed a utilization review on the services in question to determine medical necessity in accordance with 28 TAC §§134.240 and 19.2009.

This denial reason is not supported. Therefore, this dispute is not subject to dismissal based on medical necessity.

2. The insurance carrier also reduced payment for the disputed services, in part, due to lack of supporting documentation. Documentation is not required to be submitted with the medical bill for the services in dispute according to 28 TAC §133.210. When an insurance carrier needs more information to process the bill, 28 TAC §133.210 (d) requires a request to the health care provider that must:

    (1) be in writing;
    (2) be specific to the bill;
    (3) specifically describe the information to be included in the response;
    (4) be relevant and necessary for the resolution of the bill;
    (5) be for information that the health care provider has;
    (6) indicate the specific reason that the insurance carrier needs the information; and
    (7) include a copy of the bill that the insurance carrier is requesting the additional documentation for.

    The insurance carrier failed to submit evidence that it made an appropriate request for additional documentation with the required specificity. The insurance carrier's denial for this reason is not supported.

3. The insurance carrier also reduced payment for the disputed services stating, "Documentation does not support the medical necessity for confirmatory testing of more than 7 drug classes. **Reimbursement is for the appropriate supported code, G0460 and is being issued** on the EOR or a previously processed EOR [emphasis added]."

    The health care provider billed the disputed services with CPT code G0483.

    Per 28 TAC §133.240 (c), "The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value." Therefore, the insurance carrier's reduction of payment using a different CPT code's value is not supported.

4. The service in dispute, HCPCS Code G0483 is for clinical laboratory services subject 28 TAC§134.203 which states in pertinent part:

    (e) 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

Medicare's 2021 Clinical Laboratory Fee for procedure code G0483 is $246.92. DWC fee calculated at 125% is $308.65 for each for dates of service October 13, 2021, and November 24, 2021. The total allowable reimbursement is $617.30. The insurance carrier paid $414.82. An additional reimbursement of $202.48 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.

DWC finds the requester has established that additional reimbursement of $202.48 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Indemnity Insurance Co. of North America must remit to Confirmative Management Svcs, LLC $202.48 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	February 10, 2023 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.