



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Confirmative Mgmt Svcs

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-23-0424-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

October 17, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 10, 2021	80307	\$150.00	\$77.67
November 10, 2021	G0483	\$600.00	\$308.65
Total		\$750.00	\$386.32

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: \$750.00

Respondent's Position

"The bill in question were processed and denied as not authorized on 12/10/21 under cn 217407298 per the adjuster's instructions. These were not paid as there was no prior authorization. There's no reason this patient needs a drug screen monthly (which is what they're doing).

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- NABA – Reimbursement is being withheld as the treating doctor and/or service rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler
- 309 – The charge for this procedure exceeds fee schedule allowance
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- Auth – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization, pre-authorization was not obtained and treatment rendered without the approval of treating doctor. If you require additional information regarding this bill decision, contact the claim handler
- 96 – Non-covered charge(s).

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 November 10, 2021.

DWC Rule 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.”

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.”

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 based on lack of preauthorization. The DWC will now determine whether the disputed service, HCPCS Code G0483 and CPT Code 80307 rendered on November 10, 2021, required preauthorization pursuant to 28 TAC §134.600.

DWC Rule 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).”

DWC Rule 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 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 Code G0483 and 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:

Code	Date of Service	Submitted charge	Medicare Allowable	Maximum Allowable Reimbursement
80307	November 10, 2021	\$150.00	\$62.14	\$77.67
G0483	November 10, 1021	\$600.00	\$246.92	\$308.65
			Total	\$386.32

- 3. The total allowable amount is \$386.32. 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.

DWC finds the requester has established that additional reimbursement 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 respondent must remit to requestor \$386.32 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

November 21, 2022

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.