Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Choice Laboratory Service

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-12-1506-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has denied the confirmations of a urine drug screen stating that pre-authorization is required. Per Rule 134.600, a urine drug screen nor the confirmation of the drug screen are required pre-authorization items. Additionally, since the treatment falls within the Official Disability Guidelines, pre-authorization is not necessary."

Amount in Dispute: $281.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment is denied. This treatment was not authorized."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2011	Urine Drug Screen	$281.68	$281.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §133.203 sets out reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Payment is denied. This treatment was not authorized.

Issues

1. Did the disputed services require prior authorization?

2. What is the applicable rule relating to fee guidelines?
3. Is reimbursement due?

Findings

1. The workers' compensation carrier denied services, "Payment is denied. This treatment was not authorized."28 Texas Administrative Code §134.600 (p) Non-emergency health care requiring preauthorization includes…" does not list urinary drug screens as services that require prior authorization. The carrier's denial is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.

2. 28 TAC §134.203(b)(1) states that "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 initiative (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." The requestor billed the following AMA CPT codes/descriptions as follows:
    - CPT code 80102 8 units Drug confirmation, each procedure;
    - CPT code 83789, three units Mass spectrometry and tandem mass spectrometry (MS, MS/MS), analyte not elsewhere specified; quantitative, each specimen

    Review of the medical bill finds that current AMA CPT codes were billed, and that there are no CCI conflicts, Medicare billing exclusions, or medically unlikely edits (MUE) that apply to the clinical laboratory services in dispute. The requestor met 28 TAC §134.203.

3. The services in dispute are eligible for payment. 28 TAC §134.203(e) states:

    "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; and

    (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

    The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2011 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. Review of the document titled *Sample ID* finds that the provider sufficiently documented all eleven units billed. Therefore, the total MAR is calculated as follows:

    - 80102 8 Units = ($18.64 x 1.25%) x 8 = $186.40
    - 83789 3 Units = ($25.41 x 1.25%) x 3 = $ 95.28

    $281.68

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $281.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $281.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November , 2014
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.