



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CONSULTANTS IN PAIN MEDICINE

Respondent Name

TRAVELERS INDEMNITY CO

MFDR Tracking Number

M4-17-2186-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

March 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The drug screens are administered to determine patient's compliance with pharmacological pain management plan and/or to determine if non-prescribed medication is being taken by the patient."

Amount in Dispute: \$98.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 1, 2016, G0479, \$98.17, \$75.75

FINDINGS AND DECISION

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

Background

- 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 97 - Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 - Workers' compensation jurisdictional fee schedule adjustment
- 309 - The charge for this procedure exceeds the fee schedule allowance
- 6578 - Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this reevaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Is the insurance carrier's denial reason supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS Code G0479 rendered on December 1, 2016. The insurance carrier states in their position statement, "Further, the Provider failed to submit required documentation with the billing. The Medicare coding edits require that the doctor's order for urine drug screening be submitted with the billing."

28 Texas Administrative Code 133.307 (d) (2) (F) states in pertinent part,

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the EOB dated, January 13, 2017 and the reconsideration EOB dated February 16, 2017, finds that the insurance carrier raised only the denial reasons indicated above during the medical bill review process. The respondent submitted insufficient information to MFDR to support that the submitted denial reason raised in their position summary was presented to the requestor or that the requestor had otherwise been informed of this new denial reason or defense prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reason or defense. Any newly raised denial reasons or defenses shall not be considered in this review. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines in effect at the time the service was rendered.

2. The requestor is seeking reimbursement for HCPCS Code G0479 rendered on December 1, 2016. The AMA CPT Code Book as "Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service."

The insurance carrier denied the disputed service with claim adjustment reason code "97 – Payment adjusted because the benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated."

28 Texas Administrative Code §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;

Review of the Medicare payment policy at <https://www.cms.gov/medicare> relative to drug testing methods finds the provision of both presumptive testing methods and definitive methods.

Review of the applicable Medicare payment policy, coding, billing and CCI edits finds no evidence to support the insurance carrier's denial. In addition, based on the coding description, separate type of testing is found. As a result, the requestor is entitled to reimbursement for the disputed services.

3. 28 Texas Administrative Code §134.203 (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; 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.

Review of the 2016 clinical diagnostic laboratory fee schedule <https://www.cms.gov/Medicare/MedicareFee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files.html> finds the following:

Disputed HCPCS Code	Medicare Allowable	MAR
G0479	\$60.60	\$60.60 x 125% = \$75.75

The maximum allowable reimbursement is \$75.75. The carrier previously paid \$0.00. The requestor is therefore entitled to \$75.75 for disputed HCPCS Code G0479, as a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$75.75.

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 \$75.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 11, 2017

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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