



# 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**

M4-17-2417-01

**Carrier's Austin Representative**

Box Number 5

**MFDR Date Received**

April 11, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "In review of your explanation of benefits, it seems that you denied code 80307 and G0481. We feel this was denied in error. All the required information was submitted for the lab testing that performed as set forth by the Texas Administrative Code."

**Amount in Dispute:** \$399.06

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0481 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

**Response Submitted by:** Travelers

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2017	80307, G0481	\$399.06	\$277.52

### 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 medical fee guideline for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 309 – The charge for this procedure exceeds the fee schedule allowance
- T161 – For payment please provide the drug screen or lab test results
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- 247 - A payment or denial has already been recommended for this service

**Issues**

1. Are the insurance carrier’s denials supported?
2. Did the respondent raise a new issue?
3. What is the rule that applies to reimbursement?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking reimbursement for services provided on February 14, 2017 in the amount of \$399.06 for the following:

Procedure Code 80307 – “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” and

Procedure Code G0481 – “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; 8-14 drug class(es), including metabolite(s) if performed

The insurance carrier denied disputed services initially with adjustment reason code 16 – “Claim/service lacks information which is needed for adjudication.” A second explanation of benefits indicates B13 – “Previously paid. Payment for this claim/service may have been provided in a previous payment.”

Review of the submitted documentation finds no evidence of a payment for this claim. Therefore the maximum allowable reimbursement will be calculated per applicable fee guidelines.

2. The respondent states, “The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0481 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services.”

Texas Administrative Code §133.307 (2) states,

Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:

(F) 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.

The Carrier's position statement will not be considered in this dispute as review of the submitted explanation of benefits found insufficient evidence to support the Carrier presented the denial for the disputed services of "are included in the Medicare base rate for CPT code G0481 reimbursed under this date of service" prior to the date the MFDR was filed.

3. 28 Texas Administrative Code §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.

Review of the 2017 Clinical Diagnostic Laboratory Fee Schedule finds no separate allowance for the professional component. Therefore the maximum allowable reimbursement will be calculated per 28 Texas Administrative Code 134.203(e)(1).

The fee schedule amount found in 2017 Clinical Fee Schedule at [www.cms.gov](http://www.cms.gov) for code 80307 is \$61.02. This amount multiplied by 125% = MAR of \$76.28.

The fee schedule amount found in 2017 Clinical Fee Schedule at [www.cms.gov](http://www.cms.gov) for code G0481 is \$160.99. This amount multiplied by 125% = MAR of \$201.24

The total allowable is \$277.52. This amount recommended.

4. Based on requirements of Rule 134.203 the amount payable is \$277.52. The carrier previously paid \$0.00. The remaining balance of \$262.26 is due to the requestor.

**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 \$277.52.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$277.52, 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

\_\_\_\_\_  
May 19, 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 prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**