



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

Ved V Aggarwal

Respondent Name

TPCIGA for Lumbermens Mutual

MFDR Tracking Number

M4-16-3334-01

Carrier's Austin Representative

Box Number 50

MFDR Date Received

June 30, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied code stating "Authorization/notification absent", This is an error processing center, Pain Management does not have to have Authorization for this type of lab testing."

Amount in Dispute: \$468.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "These services were sent for Retrospective Utilization Review and determined to be outside of the ODG (Official Disability Guidelines) and therefore not medically necessary."

Response Submitted by: Claims Administrative Services, Inc. 501 Shelley Drive, Tyler, Texas 75701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2016	G0483, G0479	\$468.90	\$344.79

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240 sets out guidelines for medical payments and denials.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Precertification/authorization/notification absent
 - 216 – Based on the findings of a review organization
 - 18 – Duplicate claim/service

- W3 –
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are for clinical laboratory services. The carrier denied for multiple denial codes. The following is a detailed review of these denials and the applicable rules. Code G0479 – Drug test presumptive and G0483 – Drug test definitive was denied with denial code 216 – “Based on the findings of a review organization” and 197 – Precertification/authorization/notification absent. 28 Texas Administrative Code 134.240 states,

(p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

Insufficient evidence was found to support a retrospective review was performed that meets the requirements of Rule 134.240. Therefore, the insurance carrier's denial reason based on retrospective and ODG guidelines exceeded thus preauthorization required, are not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code 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 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 is calculated as follows: Medicare fee for G0479 = \$60.6 x 125% (no technical component) = \$75.75. Medicare fee for G0483 = \$215.23 x 125% = \$269.04, \$75.75 + \$269.04 = \$344.79.

3. The maximum allowable reimbursement for the services in dispute is \$344.79. The carrier previously paid \$0.00. The remaining balance of \$344.79 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 \$344.79.

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 \$344.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	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.