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
Texas Pain Relief Group

Respondent Name
Paccar Inc

MFDR Tracking Number
M4-16-2638-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 2, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sedgwick is denying these claims due to frequency. However ODG Guidelines states we can do 3 drug screens every 6 months and more if the risk level is higher."

Amount in Dispute: $274.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on May 10, 2016. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2015 October 12, 2015	G0431	$274.16	$68.92

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 §134.600 sets out Division Rules regarding preauthorization.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of preauthorization
   - W3 – Additional payment made on appeal/reconsideration

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 insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduced for absence of preauthorization." 28 Texas Administrative Code §134.600 (p) requires that (p) Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all work hardening or work conditioning services requested by:

(A) non-exempted work hardening or work conditioning programs; or

(B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury; or

(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(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);
(13) required treatment plans; and
(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

The services in dispute are related to clinical laboratory services as such no pre-authorization was required. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 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.

   The maximum allowable reimbursement is calculated as follows: Clinical laboratory fee schedule allowable = $27.57 x 125% = $34.46. Separate allowance for professional component is not applicable to this code.

3. The total allowable for the dates of service in dispute is $68.92. 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 $68.92.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $68.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June 15, 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.