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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-17-0900-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 5, 2016

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: $321.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2016	G0479, G0481	$321.56	$34.31

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. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.
4. 28 Texas Administrative Code §137.100 sets out provision of the treatment guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A05 – Service exceeds recommendations of treatment guidelines (ODG)

- CAC– 12 – Workers' compensation jurisdictional fee schedule adjustment
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed
- 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153(C)
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 920 – Reimbursement is being allowed based upon a dispute

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 requestor is seeking reimbursement of $321.56 for clinical laboratory service rendered on August 17, 2016.

   The respondent submitted as their position statement, "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

   However, at the time of payment Code G0479 denied as A05 – "Service exceeds recommendations of treatment guidelines (ODG).

   28 Texas Administrative Code §137.100 (e) states,

   > An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

   Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

   No documentation found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required.

   28 Texas Administrative Code 134.600 (p) states,

   > Non-emergency health care requiring preauthorization includes:
   >
   > > (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.

   The carrier did not deny as requiring prior authorization or perform requirements of retrospective review, therefore, Code G0479 will be reviewed based on applicable fee guideline.

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.

Review of the 2016 Clinical Laboratory Fee Schedule finds the following:

Code G0479: Drug test(s), presumptive, any number of drug classes. Allowable $60.60

Code G0481: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs. Allowable $122.99.

Neither code has a separate professional component. Therefore the MAR is calculated per 28 Texas Administrative Code §134.203 (e)(1).

Code	Submitted charge	Medicare Allowable	Maximum Allowable Reimbursement
G0479	$500.00	$60.60	$60.60 x 125% = $75.75
G0481	$630.00	$122.99	$122.99 x 125% = $153.74
		Total	$229.49

3. The total allowable amount is $229.49. The carrier paid $195.18 on December 22, 2016. The remaining balance of $34.31 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 $34.31.

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 $34.31, 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	February 8, 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.