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
Global Molecular Labs

Respondent Name
Highlands Fire Insurance Co

MFDR Tracking Number
M4-17-2683-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 12, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and denied for "pre-certification or authorization or notification absent". We have requested reconsideration from the carrier and they are maintaining the rationale. We believe this claim has been denied arbitrarily and respectfully request dispute resolution in this matter."

Amount in Dispute: $7,855.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Drug testing is outside ODG and requires UR approval. This was not approved by UR."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2017	80307, G0483	$7,855.00	$393.62

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 Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.
3. 28 Texas Administrative Code §134.600 sets out the requirements for prospective and concurrent review.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

5. 28 Texas Administrative Code §137.100 sets out the treatment guidelines for workers compensation services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider
   - 293 – This procedure requires prior authorization and none was identified
   - AUTH – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization Pre-authorization was not obtained and treatment was rendered without the approval of treating doctor. If you require additional information regarding this bill decision, contact the claim handler
   - W3 – Additional payment made on appeal/reconsideration
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler.

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 in the amount of $7,855.00 for clinical laboratory services rendered on February 2, 2017. The following submitted codes were denied by the carrier as 197 – "Payment denied/reduce for absence of precertification/authorization."

   - G0483 - 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; 22 or more drug class(es), including metabolite(s) if performed
   - 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

   The insurance carrier in its response states, "Drug testing is outside ODG and requires UR approval" making assertions that question the appropriateness and medical necessity of the services in dispute. Although these assertions are made based on language taken from the ODG, the issues raised indicate that the insurance carrier is denying payment based on medical necessity.

   The ODG, Pain, 2017, states, "*Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances*."

   Health care provided in accordance with the ODG is presumed reasonable as specified in (c) of Rule §137.100. Section (e) of that same rule allows for the insurance carrier to retrospectively review reasonableness and medical necessity:

   > "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 was 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. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding appropriateness of care and medical necessity. Therefore, 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 guideline for G0483 = $253.87 x 125% = $317.34. There is no professional component for this code. The total MAR is $317.34.

Medicare fee guideline for 80307 = $61.02 x 125% = $76.28. There is no professional component for this code. The total MAR is $76.28.

3. The maximum allowable reimbursement for the services in dispute is $393.62. The carrier previously paid $0.00. The remaining balance of $393.62 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 $393.62.

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 $393.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June 16, 2017
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.