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
PAIN MEDICS

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-19-1093-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
October 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received documentation on 3/23/2018 … which included the Medical Review … which was done 12/20/2016 … this is first time Pain Medics had received said document & only received after requested."

Amount in Dispute: $354.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Treatment is outside ODG per attached peer review. Therefore, per Rule 134.600 preauthorization is required."

Response Submitted by: Esis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 11, 2018 to April 4, 2018	Professional Medical Services	$354.28	$354.28

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 §133.250 sets out procedures for carriers to reconsider medical bills.
3. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuing an adverse determination.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. 28 Texas Administrative Code §137.100 sets out the division's treatment guidelines.
6. 28 Texas Administrative Code §134.203 sets out fee guidelines for professional medical services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Resubmit bill with appropriate ICD-10 diagnosis codes: … are invalid.
   - 146 – Diagnosis was invalid for the date(s) of service reported.
   - 197 – Precertification/authorization/notification absent.
   - Charge exceeds Fee Schedule allowance

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1 – Previous gross recommended payment amount on line: $0; Previous recommended payment amount on line: $0;
- 2 – Services not reasonable or necessary
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 4 – these are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 5 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
- W3 – (W3)

Issues

1. Are there any unresolved issues of medical necessity?
2. Was preauthorization required?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier did not raise any issues of medical necessity upon initial bill review; however, in response to the request for reconsideration the carrier denied based on reasons related to medical necessity, stating:
   - Services not reasonable or necessary
   - these are non-covered services because this is not deemed a 'medical necessity' by the payer.

   Reconsideration Rule §133.250(k) requires 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 28 Texas Administrative Code §19.2010 (relating to Requirements Prior to Adverse Determination) and §19.2011, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor.

   In support of the insurance carrier's denial, the respondent presented a peer review. Review of the submitted report finds that it is not a retrospective utilization review of the medical necessity of the disputed services. The services were performed in 2018, whereas the peer review was performed on December 20, 2016. The peer review is not related to the services in dispute. Nor did the carrier afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor before issuing the medical necessity denial. Because the carrier did not perform a utilization review of the disputed services and did not meet the requirements of Rule §133.250(k) or Rule §19.2010, the carrier's denial reasons related to medical necessity are not supported.

   The division concludes there are no unresolved issues of medical necessity. The disputed services are therefore eligible for review of the medical fee issues.

2. The carrier denied disputed services with claim adjustment reason code 197 – "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT."

   The respondent states: "Treatment is outside ODG per attached peer review. Therefore, per Rule 134.600 preauthorization is required."

   Rule §134.600(c)(1) requires the insurance carrier to be liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only when the following situations occur:

   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   The disputed services involve evaluation and management code 99213 and diagnostic service code 80305-QW.

   Rule § 134.600 (p) does not list office visits, evaluation and management services or diagnostic laboratory tests as requiring preauthorization.

However, Rule §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols…"

The commissioner's treatment guidelines are adopted by reference in Rule §137.100(a), which requires health care providers to treat "in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute…"

Review of the division treatment guidelines applicable for the dates of service finds that office visits are "recommended as determined to be medically necessary." Drug testing is also "Recommended as an option." The treatment guidelines further state:

> Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines, such as opiates or certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established.

As stated above, the submitted peer review does not relate to the disputed services and the respondent has failed to support its position that the disputed services were outside division treatment guidelines.

Based on the above information, the division concludes the disputed services were recommended by and did not exceed division treatment guidelines. Consequently, the services did not require preauthorization under Rule §134.600(p)(12). The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

3. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor. Reimbursement is calculated as follows:

   - Evaluation and management code 99213, dates of service January 11, February 7, 2018, and April 4, 2018, has a Work RVU of 0.97 multiplied by the Work GPCI of 1 is 0.97. The practice expense RVU of 1.02 multiplied by the PE GPCI of 0.938 is 0.95676. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.796 is 0.05572. The sum is 1.98248 multiplied by the DWC conversion factor of $58.31 for a MAR of $115.60, for 3 dates of service is $346.80.
   - Procedure code 80305-QW, January 11, 2018, represents a diagnostic lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $13.46. 125% of this amount is $16.83.

   The total allowable reimbursement for the disputed services is $363.63. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $354.28. This amount is recommended.

<u>Conclusion</u>

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 $354.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $354.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

____________________________	Grayson Richardson	January 18, 2019
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.