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 MD

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-19-1913-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I want to emphasize that for Pain Management Services, Authorizations are not required for the laboratory codes we are billing..."

Amount in Dispute: $266.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It remains the carrier's position that the provider is not entitled to reimbursement under G0483 as indicated on the carrier's EOBs."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2018	G0481	$266.19	$195.74

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Percertification/authorization/notification absent
   - P12– Workers' compensation jurisdictional fee schedule adjustment

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 $266.19 for clinical laboratory services rendered on August 15, 2018.

   The requirements for prior authorization are found in 28 TAC §134.600. Review of this rule found no requirement of prior authorization for the services in dispute.

   The carrier's denial based on lack of prior authorization is not supported. The code G0481 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 2018 Clinical Laboratory Fee Schedule found no separate professional component. The MAR is calculated per 28 Texas Administrative Code §134.203 (e)(1).

Code	Submitted charge	Medicare Allowable	Maximum Allowable Reimbursement
G0481	$900.00	$156.59	$195.74
		Total	$195.74

3. The total allowable amount is $195.74. 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 $195.74.

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 $195.74, 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	January 11, 2019 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.