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
M4-19-2156-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position summary submitted

Amount in Dispute: $388.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the drug testing required preauthorization and none was sought."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2018	G0481, 80307	$388.29	$285.53

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 our requirements of prior authorization.
3. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $388.29 for professional medical services rendered on September 20, 2018. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600 (p) defines the non-emergency services that require pre-authorization. The services in dispute (urinary drug screens) are not among the services that the Division requires to be pre-authorized. The carriers' denial is not supported. The services in dispute will be reviewed per applicable fee guideline.
2. The Division reimbursement guideline is found in 28 TAC 134.203 (e) which 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.

   Review of the 2018 Clinical Diagnostic Laboratory fee schedule found neither 80307 or G0481 have a professional component. The maximum allowable reimbursement is as follows:

   Code 80307 – Allowable $71.83 x 125% = $89.79

   Code G0481 – Allowable $156.59 x 125% = $195.74

   The total allowable for the services in dispute is $285.53. 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 $285.53.

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 $285.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		January 15, 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, effective May 31, 2012, *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. **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.