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
Safety National Casualty Corp

MFDR Tracking Number
M4-19-4367-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient is being prescribed Opiates, documentation to support you will find documented in the Medical Records, this gives us protocol to render UDS Testing."

Amount in Dispute: $541.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Requestor provides no documentation to justify the type of extensive drug screening/testing performed related to this patient's pain medication regimen."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2018	80307, G0481	$541.86	$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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §137.100 sets out provision of the treatment guidelines.
4. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U U sets out the requirements for utilization

review.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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 $541.86 for clinical laboratory service rendered on September 25, 2018. The insurance carrier denied the disputed service as "this documentation does not support tis many/frequency of services.

   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.

   Review of the ODG (commissioner's adopted treatment guidelines) found urine drug testing as part of pain management is recommended.

   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.

   The carrier did not perform requirements of retrospective review, therefore, Codes 80307 and G0481 will be reviewed based on applicable fee guideline.

2. The rule applicable to reimbursement is found in 28 Texas Administrative Code §134.203 (e) which 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 finds the following:

Code 80307: Drug test prsmv chem anlyzr. Allowable $71.83

Code G0481: Drug test def 8-14 classes. Allowable $156.59

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

Code	Submitted charge	Medicare Allowable	Maximum Allowable Reimbursement
80307	$183.00	$71.83	$71.83 x 125% = $89.79
G0481	$900.00	$156.59	$156.59 x 125% = $195.74
		Total	$285.53

3. The total allowable amount 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 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 $285.53, 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	July 12, 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.