TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Confirmative Mgmt Svcs

Respondent Name
Republic Franklin Insurance Co

MFDR Tracking Number
M4-22-1234-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
February 23, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 25, 2021	80307	$150.00	$77.68
March 25, 2021	G0483	$600.00	$308.65
	Total	$750.00	$386.33

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Services provided are in accordance with the DWC's treatment guidelines…"

Amount in Dispute: $750.00

Respondent's Position

At no time during the course of the claim was the claimant prescribed or had carrier acknowledged any form of prescribed medication that would support the testing,

Response submitted by: Utica National Insurance Group

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.240 sets out the guidelines for medical payment and denials.
3. 28 TAC §134.203 sets out the fee guidelines of professional medical claims.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 50 – These are non-covered services because this is not deemed a medical necessity by the payer.

Issues

1. Did the insurance carrier appropriately raise medical necessity?
2. What rule is applicable to reimbursement?

Findings

1. The insurance carrier denied disputed services as these are non-covered services because this is not deemed a medical necessity by the payer.

   DWC Rule 28 TAC §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."

   Retrospective utilization review is defined in 28 TAC §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted."

   Additionally, 28 TAC §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title and when the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior

to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute.

2. DWC Rule 134.203 (e) (1) 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 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule.

   Review of the applicable Clinical Laboratory Fee Schedule at www.cms.gov found the allowable to be as follows:

   - 80307 - $62.14 multiplied by 125% = $77.68
   - G0483 - $246.92 multiplied by 125% = $308.65

   The total allowed amount is $386.33. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that respondent must remit to requestor $386.33 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 6, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.