



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

Aggarwal, Ved MD

Respondent Name

TIG Insurance Co of Texas

MFDR Tracking Number

M4-17-1832-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 16, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim denied (Services not Authorized) the Laboratory Services rendered to the patient were at the time the patient had a Office Visit for "Pain Management" with the Physician."

Amount in Dispute: \$499.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The denied codes on this bill are used for urine drug testing for hydrocodone use. Since the hydrocodone use is considered not medically necessary, it follows that any urine drug screen for hydrocodone is also not medical necessary. Therefore, no payment is due to the provider.

Response Submitted by: Zenith Insurance Company/ZNAT Insurance Co, 1558 Sarasota, FL 34230

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2016	G0479	\$109.84	
September 2, 2016	G0483	<u>\$390.11</u>	\$344.79
		\$499.95	

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 Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Insurance Code Chapter 134.600 sets out the requirements for prior authorization of healthcare services.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

5. 28 Texas Administrative Code §137.100 sets out treatment guidelines.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 243 – Services not authorized by network/primary care providers
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment
 - 197 – Percertification/authorization/notification absent
 - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
 - 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline
 - 350 – Bill has been identified as a request for reconsideration or appeal
 - 930 – Pre-authorization required, reimbursement denied

Issues

1. Did the respondent raise a new issue?
2. Did the requestor render services to an injured employee enrolled in a certified network?
3. Are the insurance carrier’s reasons for denial or reduction of payment supported?
4. What is the rule applicable to reimbursement?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent in their position statement states, “The denied codes on this bill are used for urine drug testing for hydrocodone use. Since the hydrocodone use is considered not medical necessary, it follows that any urine drug screen for hydrocodone is also not medically necessary. Therefore, no payment is due to the provider.”

Review of the submitted documentation finds the following reason codes listed on the explanation of benefits dated October 18, 2016.

- a. 243 – Services not authorized by network/primary care provider
- b. P12 – Workers’ compensation jurisdiction fee schedule adjustment

Review of the submitted documentation finds the following reason codes listed on the explanation of benefits dated November 23, 2016

- a. 197 – Percertification/authorization/notification absent
- b. P12 – Workers compensation jurisdictional fee schedule adjustment
- c. W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Texas Administrative Code §133.307 (2) states,

Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:

(F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the submitted explanation of benefits finds insufficient evidence to support the Carrier presented the denial for the disputed services for “urine drug screen for hydrocodone is also not medically necessary” prior to the date the MFDR was filed. Therefore, the Carrier’s position statement will not be considered in this dispute.

Also included in the respondent's position statement is the following, "A previous Peer Review performed by Dr. Agana provided a proposed weaning plan off the hydrocodone. It does not appear Dr. Herrera initiated the weaning protocol. Dr. Herrera has been aware of the weaning plan since May 2015. He has not received authorization for continue hydrocodone use. The use of hydrocodone is not medically necessary per the peer review."

Review of the submitted document "Peer Review" with a date of May 5, 2015 does not address urinary drug screens. Also, the dates of service in dispute are September 2, 2016 which is after the submitted review was performed. The carrier's position is not supported and will not be considered in this review.

2. The requestor is seeking reimbursement for \$499.95 for professional medical services on date of service September 2, 2016.

The carrier denied the services in dispute as 243 – Services not authorized by network/primary care providers.

Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Review of the submitted documentation and medical claim find insufficient evidence to support that the injured worked is enrolled in a network. Therefore, the carrier's denial is not supported.

3. At the point of reconsideration, the carrier denied the services in dispute as 197 – "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p) states,

Non-emergency health care requiring preauthorization includes:

- (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
- (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;
- (3) spinal surgery;
- (4) all work hardening or work conditioning services requested by:
 - (A) non-exempted work hardening or work conditioning programs; or
 - (B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection;
- (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
 - (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
 - (i) Modalities, both supervised and constant attendance;
 - (ii) Therapeutic procedures, excluding work hardening and work conditioning;
 - (iii) Orthotics/Prosthetics Management;
 - (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
 - (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
 - (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
 - (i) the date of injury; or

- (ii) a surgical intervention previously preauthorized by the insurance carrier;
- (6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;
- (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;
- (8) unless otherwise specified in this subsection, a repeat individual diagnostic study:
 - (A) with a reimbursement rate of greater than \$350 as established in the current Medical Fee Guideline; or
 - (B) without a reimbursement rate established in the current Medical Fee Guideline;
- (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);
- (10) chronic pain management/interdisciplinary pain rehabilitation;
- (11) drugs not included in the applicable division formulary;
- (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);
- (13) required treatment plans; and
- (14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

Review of the narrative description of the submitted codes finds the following:

- G0479 Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service
- G0483 Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

These services are not found within the above stated rule as requiring prior authorization. Therefore, the carrier's denial for prior authorization is not supported.

4. The services in dispute will be reviewed per applicable rules and fee guidelines below.

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 2016 Clinical Diagnostic Laboratory Fee Schedule found at www.cms.gov finds no professional component associated with Code G0479 and G0483. Therefore, the maximum allowable reimbursement is calculated as follow:

- Procedure code G0479 has an allowable of $\$60.60 \times 125\% = \75.75
- Procedure code G0483 has an allowable of $\$215.23 \times 125\% = \269.04

5. The total allowable reimbursement for the services in dispute is \$344.79. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$344.79. This amount is recommended.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

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 \$344.79.

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 \$344.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	April 28, 2017
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 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.