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
PMSI, Inc.

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-13-0286-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We used codes S9122 for HOME HLT AID HOUR we appealed with Manufactures' Cost and Price quotes but they continue to deny as THAT CODE S9122 IS NOT A PAYABLE CODE THRU MEDICARE."

Amount in Dispute: $39,690.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that we are continuing our review of this issue and respectfully request an extension to 10/19/12."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10 – September 30, 2011	Home Health Care	$39,690.00	$0.00

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 §134.1 sets out the policies for medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W1 – Workers compensation fee schedule adjustment. The procedure code billed is not valid per Medicare payment policy as adopted by TDI-DWC. This service must be billed using a different procedure code.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Is there an applicable fee guideline for CPT code S9122?
3. What is the correct rule to determine reimbursement of the disputed services?
4. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(N)(ii)?
5. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(N)(iii)?
6. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The dispute includes dates of service from January 10, 2011 through September 30, 2011. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 25, 2012. This date is later than one year after dates of service January 10 through September 25, 2011 included in this dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file the dispute for these doates of service with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.

2. The insurance carrier denied disputed dates of service September 26, 27, 28, 29, and 30, 2011 in part, stating, "…THE PROCEDURE CODE BILLED IS NOT VALID PER MEDICARE PAYMENT POLICY AS ADOPTED BY TDI-DWC…" The disputed services involve CPT code S9122, defined as "Home health aide or certified nurse assistant, providing care in the home; per hour."

   Home health services are subject to the fee guidelines found in 28 Texas Administrative Code §134.204 (f), which states, "To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies." Review of the published Texas Medicaid fee schedule effect September 4, 2011 finds that Medicaid does not include a fee for CPT code S9122. Therefore, the Division concludes that there is not an applicable fee guideline for disputed CPT code S9122.

3. 28 Texas Administrative Code §134.203 (f) states, in relevant part, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204 (f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title."

   The disputed CPT Code does not have an established relative value unit or payment assigned by Medicare or Texas Medicaid. Accordingly, reimbursement is determined under the general medical reimbursement provisions of 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement.

   28 Texas Administrative Code §134.1 requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection (f), which states that

   > Fair and reasonable reimbursement shall:
   > (1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011(d) requires that

> fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.

It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. 28 Texas Administrative Code §133.307(c)(2)(N)(ii), requires that the request shall include a position statement of the disputed issues including "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(ii).
5. 28 Texas Administrative Code §133.307(c)(2)(N)(iii), requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor's position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(iii).
6. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide

   > documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title … when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.

   Review of the submitted documentation finds that:

   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	November 4, 2015
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.