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
MAXIM HEALTHCARE SERVICES, INC.

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-13-0319-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: [The injured employee] "has a letter of agreement to be reimbursed at $26.00 per hour for service code G0156. I am asking that dates of service 11/30/11-5/12/12 be reprocessed and pay an additional $16,892.53 to close this account as paid in full."

Amount in Dispute: $16,892.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of the Agreement is 7/16/12. There is nothing in the Agreement . . . that insinuates, hints, or implies . . . the Agreement is retroactive. . . . For its part the requestor has not provided any evidence the Agreement does apply retroactively."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 30, 2011 to May 12, 2012	Home Health Services	$16,892.53	$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 §134.204(f) sets out the fee guideline for home health services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT.

- 426 – REIMBURSED TO FAIR AND REASONABLE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- 18 – DUPLICATE CLAIM/SERVICE.
- 226 – DUPLICATE CHARGE.
- 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)

Issues

1. Are the disputed services subject to a negotiated agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement of the disputed home health services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor submitted a copy of a letter of agreement (LOA) between the health care provider and the insurance carrier contracting for an hourly rate, effective July 16, 2012. The effective date of the LOA is after the dates of service in dispute. The LOA does not specify that the contracted rate is applicable to services performed before the effective date of the agreement. The Division therefore finds that reimbursement for the disputed services is not subject to a contract between the parties. Reimbursement will therefore be determined per applicable Division rules and fee guidelines.
2. This dispute regards health aide and home health services provided by a home health agency. According to the Texas Department of Aging and Disability Services' Directory for Home and Community Support Services Agencies, the health care provider is a licensed home health agency. Reimbursement for the disputed services is therefore subject to the provisions of 28 Texas Administrative Code §134.204(f) which requires that "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."
3. The Texas Medicaid fee schedule allowance for disputed procedure code G0156 is $46.09 per visit. 125% of this amount is $57.61. The submitted medical bills document 85 dates of service, for a total MAR of $4,897.00. The insurance carrier has paid $4,997.00. No additional reimbursement is 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 on the submitted information, pursuant to Texas Labor Code Sec. 413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 2, 2016
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.