



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Denise Turboff, L.P.C.

Respondent Name

City of Houston

MFDR Tracking Number

M4-15-3205-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

May 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These procedures were done in conjunction to a work hardening program that [claimant] was approved for... Per ODG guidelines WH patients need to see a psychologist 1 time a week for 1 hour to determine stress levels and pain tolerance before being able to return to work..."

I received a check from the insurance carrier in which they agreed to reimburse us for procedure code (cpt code 97799), in the amount of \$563.70... I wish to have a MFDR specialist review this payment and explain to me how the insurance carrier came about this dollar amount..."

Amount in Dispute: \$700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation an additional payment is being made at this time in amount of \$563.70 including interest."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 20 & 23, 2015, Work Hardening Psychology Services, \$700.00, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 general provisions regarding medical reimbursement.

3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent.
 - PI – Payer initiated
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
 - OA – Other adjustments
 - 222 – Charge exceeds fee schedule allowance
 - P12 – Workers Compensation Jurisdictional Fee Schedule adjustment.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(J)?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(M)?
3. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(N)(i)?
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. What is the applicable fee guideline to determine the reimbursement for the disputed services?
7. What is the applicable rule for determining reimbursement of the disputed service?
8. 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)(2)(J), requires that the request shall include “a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250” Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).
2. 28 Texas Administrative Code §133.307(c)(2)(M), requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute.” Review of the submitted documentation finds that the requestor has not provided copies of all medical records specific to the dates of service in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(M).
3. 28 Texas Administrative Code §133.307(c)(2)(N)(i), requires that the request shall include a position statement including “the requestor’s reasoning for why the disputed fees should be paid.” Review of the submitted documentation finds that the requestor has not explained the requestor’s reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(i).
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. The requestor indicates in their position statement that “these procedures were done in conjunction to a work hardening program...” The disputed services are regarding CPT Code 97799, which represents an “unlisted physical medicine/rehabilitation service or procedure,” a professional medical service subject to the fee guidelines found in 28 Texas Administrative Code §134.203.

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. Therefore, the Division has not established an applicable fee guideline for this service. Accordingly, reimbursement is determined under the general medical reimbursement provisions of 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement.

7. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1. This rule 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.

8. 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’s position statement does not provide a rationale for increased reimbursement from the insurance carrier.
- The Division has previously found, as stated in the adoption preamble to the former Acute Care Inpatient Hospital Fee Guideline, that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors” (22 Texas Register 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they “allow the hospitals to affect their reimbursement by inflating their charges” (22 Texas Register 6268-6269). While the requestor is not a hospital, the above principle is of similar concern in the present dispute. A health care provider’s usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Payment of billed charges is not acceptable when it leaves the ultimate reimbursement in the control of the health care provider—which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living.

Therefore, the use of a health care provider's billed charges cannot be favorably considered unless other data or documentation is presented to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- 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 additional 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.

9. The insurance carrier reimbursed \$563.70 for the disputed services. The requestor is not eligible for additional reimbursement for these services.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish 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 services in dispute.

Authorized Signature

_____	Laurie Garnes	_____
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, effective May 31, 2012, *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 MDR 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.