



# 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**

Salvador P. Baylan, M.D., P.A.

**Respondent Name**

City of San Antonio

**MFDR Tracking Number**

M4-16-0690-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 16, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** Review of the submitted documentation does not find a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

**Amount in Dispute:** \$1185.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Per an RME performed by Dr. G. Peter Foon MD dated 04/22/2015, the injection therapy is clearly not indicated per ODG."

**Response Submitted by:** Argus Services Corporation

### SUMMARY OF FINDINGS

| Dates of Service | Disputed Services          | Amount In Dispute | Amount Due |
|------------------|----------------------------|-------------------|------------|
| June 16, 2015    | Epidural Steroid Injection | \$1185.00         | \$457.94   |

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
- 28 Texas Administrative Code §134.1 sets out the procedures for medical reimbursement.
- 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
- 28 Texas Administrative Code §19.2003 provides definitions for terms related to utilization reviews.
- 28 Texas Administrative Code §19.2009 sets out the procedures for notices of determination of utilization reviews.

7. 28 Texas Administrative Code §19.2010 provides the requirements prior to issuing adverse determinations of utilization review.
8. Texas Labor Code §413.011 sets out the policies and guidelines for reimbursement.
9. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 50F – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. \*Not medically necessary per designated doctor exam and/or required medical exam.\*
  - 50K – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. \*Not recommended per the Official Disability Guidelines (ODG)\*
  - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers’ Compensation State Fee Schedule.

### **Issues**

1. Did the insurance carrier appropriately raise medical necessity for this dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed service?
3. Is the requestor entitled to reimbursement for the disputed service?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason codes 50F – “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. \* Not medically necessary per designated doctor exam and/or required medical exam\*,” and 50K – “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. \*Not recommended per the Official Disability Guidelines (ODG)\*.”

Retrospective utilization review is defined in 28 Texas Administrative Code §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.

In addition, 28 Texas Administrative Code §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 ... Additionally, in any instance where 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. Because denial of the disputed services was not supported, they are reviewed in accordance with applicable rules and fee guidelines. 28 Texas Administrative Code §134.203(c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is \$56.20.

For procedure code 62311 on June 16, 2015, the relative value (RVU) for work of 1.54 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 1.540000. The practice expense (PE) RVU of 4.61 multiplied by the PE GPCI of 0.920 is 4.241200. The malpractice (MP) RVU of 0.14 multiplied by the MP GPCI of 0.822 is 0.115080. The sum of 5.896280 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$331.37.

For CPT code 77003 on June 16, 2015, the RVU for work of 0.60 multiplied by the GPCI for work of 1.000 is 0.600000. The PE RVU of 1.76 multiplied by the PE GPCI of 0.920 is 1.619200. The MP RVU of 0.04 multiplied by the MP GPCI of 0.822 is 0.032880. The sum of 2.252080 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$126.57.

28 Texas Administrative Code §134.203(b)(1) states ,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Per the 2015 *NCCI Policy Manual for Medicare Services*, Chapter 12, Section A,

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare & Medicaid Services (CMS) as a complementary coding system to the CPT Manual. These codes describe physician and non-physician services not included in the CPT Manual, supplies, drugs, durable medical equipment, ambulance services, etc.

Disputed HCPCS codes J3301 and J3490 are HCPCS Level II codes. Therefore, the guidelines outlined in 28 Texas Administrative Code §134.203(d) apply to these codes. 28 Texas Administrative Code §134.203(d) states,

The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
- (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
- (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Disputed HCPCS codes J3301 and J3490 do not have fees listed in the Medicare DMEPOS fee schedule or the Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS. 28 Texas Administrative Code §134.203(f) states

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 (relating to Medical Reimbursement).

28 Texas Administrative Code §134.1(e) 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 a fair and reasonable amount made in accordance with subsection §134.1(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. The commissioner shall consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) states the request for dispute resolution shall include:

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 does not demonstrate or justify that the amount of \$280.00 sought for disputed HCPCS code J3301 or the amount of \$105.00 sought for disputed HCPCS code J3490 would be fair and reasonable reimbursement. Therefore, no reimbursement can be recommended for these codes.

- 3. The total reimbursement amount for the disputed services is \$457.94. The insurance carrier paid \$0.00. A reimbursement of \$457.94 is recommended.

**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 \$457.94.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$457.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

|           |  |                  |
|-----------|--|------------------|
|           | Laurie Garnes                          | January 15, 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.**