



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

Cody Carter, D.C.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-3437-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$1300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 12/4/15 paid \$500.00 for code 99456-W5/WP, \$500.00 for 99456-W8/RE, and \$36.00 for code 99199 (translation services).

In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay an additional \$150.00 for 99456-W5/WP. However, Texas Mutual made a fair and reasonable payment for translation services, code 99199. The requestor has not shown that \$150.00 reimbursement for code 99199 is either fair or reasonable."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2015	Designated Doctor Examination with Translation Services	\$1300.00	\$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 forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - CAC-P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
 - 426 – Reimbursed to fair and reasonable.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. What are the services in dispute?
2. What are the applicable rules and statutes for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for a Designated Doctor Examination, represented by procedure codes 99456-W5-WP and 99456-W8-RE, and translation services, represented by procedure code 99199. Review of the submitted documentation finds that the insurance carrier paid procedure codes 99456-W5-WP and 99456-W8-RE in full per Explanations of Benefits dated December 4, 2015 and July 29, 2016. Therefore, these services will not be considered for this dispute.

The requestor is seeking a total of \$150.00 for procedure code 99199. Per Explanation of Benefits dated December 4, 2015, the insurance carrier reimbursed \$36.00. This service will be reviewed for the dispute in question.

2. 28 Texas Administrative Code §134.203 states, in relevant part:

- (f) 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).

The division finds that no relative value unit or payment has been assigned by Medicare, Medicaid, or the Division. Therefore, reimbursement is subject to the requirements of 28 Texas Administrative Code §134.1, which requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement shall be made in accordance with subsection (f), which states:

- (f) 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.

Review of the submitted documentation does not support that a negotiated contract exists for the disputed service. Therefore, reimbursement is subject to fair and reasonable requirements in accordance with 28 Texas Administrative Code §134.1(f).

3. 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 (relating to Medical Reimbursement) ... 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 submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- 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.

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 additional reimbursement for the services in dispute.

Authorized Signature

_____	Laurie Garnes	August 18, 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.