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
LONE STAR NEUROLOGY-FRISCO

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M4-17-2880-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a by report code and should be paid according to billed charges."

Amount in Dispute: $54,552.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor was reimbursed at the reimbursement amount of the Medical Fee Guideline . . . for 3 units of CPT code 95953, which is a similar procedure. The CPT code 95951 has a status indicator of 'C' that means the carrier prices the code. Reimbursement was made at fair and reasonable."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2016 to October 19, 2016	Electroencephalogram Monitoring & Analysis, 95951, 95957, 93268	$54,552.48	$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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P5 – Based on payer reasonable and customary fees.
     - Fair and reasonable reimbursement based on fee schedule reimbursement of CPT code 95953.
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - W3 – Additional reimbursement made on reconsideration.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (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) . . . 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. . . .

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor.

   The applicable division conversion factor for calendar year 2016 is $56.82.

   Reimbursement is calculated as follows:

   - Procedure code 95951 has status indicator C, denoting services for which payment is established on an individual case basis upon review of documentation. If reimbursement is justified, this code is paid at a fair and reasonable rate. Neither CMS nor the division has assigned a relative value or payment. Payment is thus subject to Rule §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $1,910.97. The requestor asked for reimbursement equal to the full billed charges. The division has previously held that billed charges are neither evidence of a fair and reasonable rate nor of what insurance carriers pay for the same or similar services. Payment of billed charges is thus not acceptable when it leaves the health care provider in control of the amount paid—which would ignore the objective of effective cost control and statutory standards not to pay more than that paid for similar treatment of similar patients. Therefore a provider's charge cannot be favorably considered unless other evidence is submitted to support that the payment sought is a fair and reasonable reimbursement for the disputed services. The provider did not discuss, demonstrate, or justify that the amount sought is fair and reasonable in accordance with Rule §134.1. The respondent, on the other hand, discussed and justified by a preponderance of the evidence that the amount paid was fair and reasonable. Review of the submitted information finds insufficient information to support a different payment from the amount determined by the insurance carrier; additional reimbursement is not recommended.
   - Procedure code 95957 is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 1.98 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.98. The practice expense (PE) RVU of 6.8 multiplied by the PE GPCI of 0.92 is 6.256. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.822 is 0.10686. The sum of 8.34286 is multiplied by the division conversion factor of $56.82 for a MAR of $474.04 at 3 units is $1,422.12.
   - Procedure code 93268 is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 0.52 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.52. The practice expense (PE) RVU of 5.23 multiplied by the PE GPCI of 0.92 is 4.8116. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.822 is 0.03288. The sum of 5.36448 is multiplied by the division conversion factor of $56.82 for a MAR of $304.81 at 3 units is $914.43.

2. The total allowable reimbursement for the services in dispute is $4,247.52. The insurance carrier paid $4,247.52, leaving an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	July 7, 2017
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.