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
Texas Health HEB

Respondent Name
General Motors

MFDR Tracking Number
M4-17-3274-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges..."

Amount in Dispute: $302.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent stands by the original payment for the service in dispute. Requestor was reimbursed pursuant to the Medicare fee guidelines for the total outpatient procedure."

Response Submitted by: Downs • Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2016	27658	$302.89	$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 §134.403 sets out the payment requirements for outpatient hospital services.
3. 28 Texas Administrative Code §134.1 sets out medical reimbursement policies.
4. Texas Labor Code §413.011 reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – Payment adjusted because the benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated

- W3 – Additional payment made on appeal/reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to the reimbursement of the services in dispute?

Findings

1. The requestor is seeking $302.89 for Code 27658 - "Repair, flexor tendon, leg; primary, without graft, each tendon" rendered on July 13, 2016.

   The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.403(d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…

   Review of the submitted medical bill found in box 56 the NPI 1104845015 and in box 57 the number 751438726. Researching the National Plan and Provider Enumeration System at https://nppes.cms.hhs.gov/ found the number referenced in box 57 is not a valid Medicare provider number. Further research for the NPI 1104845015 found no valid Medicare number for this NPI.

   28 Texas Administrative Code §134.403 (f) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.*

   As the submitted medical bill did not identify a valid Medicare provider number, the Medicare facility specific amount cannot be determined. Therefore the provisions of 28 Texas Administrative Code §134.403 (e) (3) states,

   > If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

   The carrier's denial is not supported. The service in dispute will be reviewed per applicable fee guidelines discussed below.

2. The general payment provisions of 28 Texas Administrative Code §134.1 require that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).

   28 Texas Administrative Code §134.1(f) requires 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.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." Texas Workers' Compensation Commission v. Patient Advocates of Texas, 136 South Western Reporter Third 656 (Texas 2004).

Additionally, the Third Court of Appeals has held, in All Saints Health System v. Texas Workers' Compensation Commission, 125 South Western Reporter Third 104 (Texas Appeals – Austin 2003, petition for review denied), that "each . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

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 this subtitle in establishing the fee guidelines.

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 . . . 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 information finds that the requestor did not discuss, demonstrate or justify how the requested reimbursement meets the requirements of §134.1(f). The requestor has failed to support that the requested payment would result in a fair and reasonable reimbursement for the services in dispute.

The insurance carrier allowed $4,365.25. The Division finds that the requestor has not established that additional reimbursement is due, as a result, additional reimbursement 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 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

		August 4, 2017
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 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.