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**
Lone Star Neurology

**Respondent Name**
Lewisville ISD

**MFDR Tracking Number**
M4-18-1338-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
January 12, 2018

## *REQUESTOR'S POSITION SUMMARY*

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

**Amount in Dispute:** $54,509.10

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Starr maintains its position that reimbursement of $1,956.39 was fair and reasonable and reflects a standardized reimbursement structure."

**Response Submitted by:** Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 7, 2017 to April 9, 2017 | 95951, 95957, 93268 | $54,509.10 | $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 reimbursement guidelines 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
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – Additional reimbursement made on reconsideration
- 193 – Original payment decision is being maintained. This claim was processed properly the first time

**Issues**

1. Is the carrier's position supported?
2. What is the applicable rule for determining reimbursement of professional medical services?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement in the amount of $54,509.10 for professional medical services rendered on April 7, 2017, April 8, 2017, and April 9, 2017. The respondent states, "…Reimbursement was made at fair and reasonable."

   Procedure code 95951, for date of service April 7, 8, and 9, 2017. This code has status indicator C, denoting services for which payment is established on an individual case basis after review of documentation; if reimbursement is justified, this code is paid at a fair and reasonable rate.

   This code is not assigned a relative value or payment. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires 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 Rule §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.

   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 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

   The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

   Review of the submitted documentation finds that:

   - No position statement was submitted by the requestor.
   - The requestor did not explain or provide documentation to support how the proposed methodology ensures quality medical care to injured workers.
   - The requestor did not explain or provide documentation to support how the proposed methodology achieves effective medical cost control.

- The requestor did not explain or provide documentation to support how the proposed methodology ensures that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not explain or provide documentation to support that the proposed methodology is consistent with the criteria of Labor Code §413.011.
- The requestor did not explain or provide documentation to support that the proposed methodology satisfies the requirements of Rule §134.1

In the following analysis, evidence was presented only by the respondent to support their position as to the fair and reasonable payment amount. Based on the above, the insurance carrier's position statement is supported.

The insurance carrier allowed $1,956.39. Review of the submitted information finds insufficient information to support a different payment from that determined by the insurance carrier; additional reimbursement is not recommended.

The remaining services in dispute are discussed below.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

> 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 (date of service yearly conversion factor).

The maximum allowable reimbursement is calculated as follows:

- Procedure code 95957, April 7, 8, and 9, 2017. The Medicare physician fee schedule allowable is $292.51. The Medicare Conversion factor is $35.8887. The Division conversion factor is $57.50. The MAR is calculated by (DWC Conversion Factor/Medicare Conversion Factor) x Allowable Amount = MAR or (57.50/35.8887 x $291.51) = $468.65 X 3 units = $1,405.95. The carrier paid $1,405.95. No additional payment is recommended.
- Procedure code 93268, April 7, 8, and 9, 2017. The Medicare physician fee schedule allowable is $193.19. The Medicare Conversion factor is $35.8887. The Division conversion factor is $57.50. The MAR is calculated by (DWC Conversion Factor/Medicare Conversion Factor) x Allowable Amount = MAR or (57.50/35.8887 x $193.19) = $309.52 X 3 units = $928.56. The carrier paid $928.56. No additional payment is recommended.

3. The request for additional reimbursement is not supported. After thorough review of the submitted information, the division concludes the requestor has failed to discuss, demonstrate, and justify that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, additional reimbursement cannot be 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 available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

The applicable rule for determining reimbursement of the disputed services is 28 Texas Administrative Code §134.1, regarding a fair and reasonable reimbursement.

For the reasons stated above, the division finds 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**

| | | |
|---|---|---|
| | | February 6, 2018 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | February 6, 2018 |
| 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**.