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
PLANO INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-18-3605-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position Summary was not submitted in the request for medical fee dispute packet.

Amount in Dispute: $42,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's CMS-1500 under CPT code 95951 had modifiers of 49 and 76. That allows a professional reimbursement amount of $509.35. The provider billed for three units. Thus, the total reimbursement was $509.35 multiplied by three which totals $1,528.05. We would point out that CPT code 95951 does not have a technical component allowance. This is true not only in the Medical Fee Guideline but also the Medicare Fee Schedule. Accordingly, under CPT code 95951, the only allowance reimbursable was the professional allowance. The documentation did not support an allowance of $42,000.00 for CPT code 95951. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2017 through October 18, 2017	CPT Code 95951-59-76 (X3)	$42,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1, provides for fair and reasonable reimbursement of health care in the

absence of an applicable fee guideline.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers Compensation jurisdictional fee schedule adjustment. Charge exceeds Fee Schedule allowance.
   - 6000-Request for reconsideration.
   - 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.
   - 18-Exact duplicate claim/service.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor entitled to additional reimbursement for codes 95951-59-76?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. Based upon the submitted documentation the requestor billed $42,000.00 and was paid $1,528.05 for code 95951-59-76. The issue in dispute is whether the requestor is due additional reimbursement for code 95951-59-76.

   28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service, the requestor billed 95951-59-76, 95957-59-76 and 93268-59-76. Only code 95951-59-76 is in dispute.

   - CPT code 95951 is described as "Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours."
   - The requestor appended modifiers "59- Distinct procedural service" and "76-Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional" to this code.

   A review of Medicare's fee schedule finds CPT code 95951-59-76 does not have a Medicare assigned relative value.

   Because CPT code 95951-59-76 does not have a Medicare assigned relative value the division refers to 28 Texas Administrative Code §134.203(f).

   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)(3) states, " in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."

   28 Texas Administrative Code §134.1(f)(1-3) states, "Fair and reasonable reimbursement shall: be consistent with the criteria of Labor Code §413.011; ensure that similar procedures provided in similar circumstances receive similar reimbursement; and 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.

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) or §134.503 of this title (relating to Pharmacy Fee Guideline) 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 discuss or explain how reimbursement $42,000.00 for code 95951-59-76 is a fair and reasonable reimbursement. 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.

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

		2/5/2019
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, 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 MDR 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.