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 Podiatry

Respondent Name
Tx Public School WC Project

MFDR Tracking Number
M4-19-3274-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…a pre-auth was requested for the Q4169 and the application CPT code 15271 back in September and approved on 9/21/18..."

Amount in Dispute: $20,805.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CRF paid for the services associated with ICD-10 codes 15275 and 97597 upon receipt of Lone Star's October 16, 2018 bill. However, Lone Star failed to obtain preauthorization for all other services in question. Consequently, Lone Star has not established that it is entitled to reimbursement for the services in dispute."

Response Submitted by: Creative Risk Funding, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2018 through November 15, 2018	Q4169, 15275, 97597	$20,805.00	$1,477.72

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 §134.600 sets out the requirements for prior authorization.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 284 – Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 193 – Payment denied/reduced for exceeded precertification/authorization
   - 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
   - Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule(s) are applicable to reimbursement?
3. Is the requestor due additional reimbursement?

Findings

1. The insurance carrier denied disputed services for the absence of authorization and the payments were made based on the workers' compensation jurisdictional fee schedule.

   The requestor states, "a pre-auth was requested for the Q4169 and the application CPT code 15271 back in September and approved on 9/21/18." Review of the submitted documentation finds;

   - Authorization # 117418 – Dates of Service – 9/21/18 to 10/21/18 for CPT 15004, 15275, 15777 Determination note: IMO has preauthorized medical necessity for Skin Substitute: Artacent for Wound Dehiscence to be done on an outpatient basis

   - Authorization #117418 – Dates of Service have been extended through 11/30/2018

   The requestor's position is supported. The carrier's denial for lack of pre-authorization is not supported.

2. Regarding the disputed Code Q4169. This code is excluded from the physician fee schedule and is not payable under the Medicaid fee schedule. 28 TAC 134.201 (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, states,

   > 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.

   28 TAC §133.307(c)(2)(O), applicable to requests filed on or after June 1, 2012, 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 has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that $215 per unit is a fair and reasonable amount.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- 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 TAC §134.1. 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.

3. The reimbursement amounts for Code 15275 and 97597 are reimbursed based on 28 TAC 134.203 (c) which 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).

Date of Service	Billed Code	Allowed amount	MAR	Insurance carrier paid	Amount due
October 16, 2018	15275	$147.01	58.31/35.9996 x $147.01 = $238.12	$238.12	$0.00
October 16, 2018	97597	$81.07	58.31/35.9996 x $81.07 = $131.31	$131.31	$0.00
October 24, 2018	15275	$147.01	58.31/35.9996 x $147.01 = $238.12	$0.00	$238.12
October 24, 2018	97597	$81.07	58.31/35.9996 x $81.07 = $131.31	$0.00	$131.31
November 1, 2018	15275	$147.01	58.31/35.9996 x $147.01 = $238.12	$0.00	$238.12
November 1, 2018	97597	$81.07	58.31/35.9996 x $81.07 = $131.31	$0.00	$131.31
November 8, 2018	15275	$147.01	58.31/35.9996 x $147.01 = $238.12	$0.00	$238.12
November 8, 2018	97597	$81.07	58.31/35.9996 x $81.07 = $131.31	$0.00	$131.31
November 15, 2018	15275	$147.01	58.31/35.9996 x $147.01 = $238.12	$0.00	$238.12
November 15, 2018	97597	$81.07	58.31/35.9996 x $81.07 = $131.31	$0.00	$131.31
			Total	$369.43	$1,477.72

The allowed amount for the services in dispute that were prior authorized based on submitted evidence, is $1,847.15. The carrier paid $369.43. The remaining balance of $1,477.72 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,477.72.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,477.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		March 29, 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 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.