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
ORTHOTEXAS PHYSICIANS AND SURGEONS

MFDR Tracking Number
M4-19-4547-01

MFDR Date Received
June 18, 2019

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

Carrier's Austin Representative
Box Number 47

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was given an arm cradle, which is a 'cash-pay' item in our office. This is now being billed to your company under the CPT code A9999, miscellaneous DME supply because there is no other CPT code for this DME. I am resubmitting this claim(s) for payment reconsideration. I have also included in this submission the medical documentation."

Amount in Dispute: $35.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the invoice provided in the documentation this is a billing for foam block placed on/around the arm for stability... This is the positioner, not the sling or splint itself. Based on this information, the most appropriate code would be E0190... Should you have any questions or concerns, please do not hesitate to contact me."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 10, 2019	A9999	$35.00	$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 531 – Please re-submit with the appropriate HCPCS/CPT code
   - 16 – Claim/service lacks information which is needed for adjudication
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Is the insurance carrier's denial reason(s) supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed HCPCS Code A9999 rendered on April 10, 2019. The insurance carrier in the position summary states in pertinent part, "This is the positioner, not the sling or splint itself. Based on this information, the most appropriate code would be E0190."

   28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (O) 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."

   28 Texas Administrative Code §133.307 states in pertinent part, "(c)(4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided..."

   28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

2. The disputed items are durable medical equipment billed under code A9999 for an Arm Cradle. Medicare does not assign a value to this item and the TDI, DWC has not established a medical fee guideline for this item. 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:
   >
   > a. be consistent with the criteria of Labor Code §413.011;
   > b. ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > c. 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* 643, 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* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . 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 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.

3. The division first reviews the information presented by the requestor to determine whether it has met the burden to show that the payment amount it is seeking is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, then the division will review the respondent's evidence.

   Review of the submitted documentation finds that:

   - The requestor did not submit information to support a fair and reasonable price for the disputed items. The table of disputed services indicates that the amount in dispute for the items is the amount billed.
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269).

     While durable medical equipment is not the same as an inpatient hospital admission, the above principle is of similar concern in the present case. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Thus, payment of the billed charges is not acceptable when it leaves the ultimate reimbursement in the control of the health care provider— which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. Therefore, the use of a health care provider's "usual and customary" charges cannot be favorably considered unless other data or documentation is submitted to support that the payment amount sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not explain or provide documentation to support how the requested payment amount ensures quality medical care to injured workers.
   - The requestor did not explain or provide documentation to support how the proposed payment amount achieves effective medical cost control.
   - The requestor did not explain or provide documentation to support how the requested payment amount ensures that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not explain or provide documentation to support that the requested payment amount is consistent with the criteria of Labor Code §413.011.
   - The requestor did not explain or provide documentation to support that the requested payment amount satisfies the requirements of Rule §134.1.

   The request for reimbursement is not supported. After a 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, 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 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 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 18, 2019 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.