TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GEORGE T. BROWN, MD

MFDR Tracking Number
M4-21-0053-01

MDR Received Date
September 11, 2020

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Representative
Box Number 54

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Our billing for Phonak, Audeo P90-R BTE hearing aids is $7,200.00. This cost includes the hearing aids, professional fitting fee, and one year of follow up care at no cost to the Insured. When… was fit with his initial hearing aids in 2011 our office billed $7,200.00 and was paid this amount. In 2016 he received new aids, and again our office billed $7,200.00, but we were paid only $6,120.00. This year, 2020, our office again bill $7,200.00 for… new aids but was paid $5,071.00 [sic]. We have billed the same amount each year, even thought our cost has gone up. Our reimbursement from the Insurance Company has gone down each time."

RESPONDENT'S POSITION SUMMARY

"Upon review of the DWC60 dispute the provider submitted invoice or explanation of cost from the manufacturer Phonak for the BTE Hearing Aids which was previously not submitted on appeal. HCPCS codes V5261 and V5267 both are unlisted codes per DMEPOS (Medicare), and Medicaid Fee Schedule instructs manual review and pricing for each code per 5 and 5B notes in the TMHP Static Fee Schedule. Texas Mutual will reprocess the bill in accordance to Rule 134.203(d)(l-3)(f). Per review of the cost to the provider which was provided by Phonak, Texas Mutual will reprocess the bill per Fair and Reasonable Rate in accordance to Rule 134.1, which consist of cost to the provider as noted per Phonak + 10% markup."

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 6, 2020	V5261 and V5267	$7,678.33	$2,606.45

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 892,225 - AN UNLISTED CODE THAT HAS NO ESTABLISHED FEE SCHEDULE REIMBURSEMENT AMOUNT REQUIRES DOCUMENTATION (ITEMIZED STATEMENT/COST ACQUISITION FORM OR MANUFACTURERS INVOICE) EXPLAINING HOW THE BILLED AMOUNT OF $7200.00 IS FAIR AND REASONABLE PER RULE 134.1 (F)

- CAC-P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 420 - SUPPLEMENTAL PAYMENT.
- 790 - THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 892 - DENIED IN ACCORDANCE WITH RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS

Findings

1. The requestor seeks reimbursement for services billed under HCPCS codes V5261 and V5267. The insurance carrier issued a payment in the amount of $21.67 for HCPCS Code V5267 and issued a payment for HCPCS Code V5261 in the amount of $5071.88 after the filing of the DWC060, payments totaling $5093.55. The insurance carrier denied the remaining charges with reduction codes, CAC-P12, CAC-W3, CAC-193, 350, 420, 790 and 892 (descriptions provided above.)

   In order to determine whether the insurance carrier issued the correct reimbursement, the DWC applies the following:

   28 TAC §134.203 (c) states in pertinent part, "28 TAC §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."

   HCPCS Codes V5261 and V5267 are defined as:

   V5261 – Hearing aid, digital, binaural, bte

   V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified.

   The DWC finds that the services in dispute are not assigned a relative value unit or payment by Medicare and Texas Medicaid and therefore, are subject to 28 TAC §134.203(f).

   28 TAC §134.203 states, "(f) 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)."

   This dispute relates to services with reimbursement subject to the provisions of 28 TAC §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states 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."

2. 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.

3. 28 TAC §133.307(c)(2)(N)(ii), applicable to requests filed on or after June 1, 2012, requires that the request shall include a position statement including "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(ii).

4. The DWC will review the information presented by the requestor to determine whether the burden is met to show the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services. If the requestor's evidence is persuasive, the division will then review the evidence presented by the respondent to support that the amount paid was a fair and reasonable reimbursement for the disputed services. Rule 28 TAC §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 documentation finds that:

- The requestor seeks payment of their full billed charges of $7,700.00.
- 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.
- Payment of the provider's billed charge is thus not acceptable when it leaves the payment amount in the health care provider's control — 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.
- Accordingly, the use of a health care provider's "usual and customary" charges cannot be favorably considered unless other data or documentation is presented to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In this dispute, however, the requestor has submitted additional information to support that $7,700.00 is a fair and reasonable reimbursement amount.
- The requestor submitted redacted copies of EOBs from different insurance carriers showing payment for the same or similar services of the full requested amount of $7,700.00.
- The submitted evidence supports that a number of diverse payers found this amount to be an acceptable payment for the services in dispute.
- The documentation supports that the proposed payment achieves effective medical cost control while still ensuring the quality of medical care.
- It shows that similar procedures provided in similar circumstances have received similar reimbursement.
- The division finds the requested amount to be consistent with the criteria of Labor Code §413.011.

The division concludes the requestor has satisfied the requirements of Rule 28 TAC §134.1.

The request for additional reimbursement is supported. The division concludes the requestor has discussed, demonstrated, and justified that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. The insurance carrier issued payments totaling $5,093.5577. As a result, the requestor is entitled to an additional reimbursement amount of $2,606.45.

Conclusion

For the reasons stated above, the DWC finds that the requestor has stablished that reimbursement is due. As a result, the amount ordered is $2,606.45.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $2,606.45 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 17, 2021 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 TAC §133.307, 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 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.