TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PARADIGM NEURODIAGNOSTICS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-23-2512-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 27, 2022 through December 29, 2022	95700, 95716, and 95724	$37,845.31	$0.00
	Total	$37,845.31	$0.00

Requestor's Position

"DESIGNATED DOCTOR REFERRED TESTING."
Amount in Dispute: $37,845.31

Respondent's Position

"Payment for these services was made per Texas fee guidelines. Texas Mutual utilized the Novitas participating amount per the schedule below:
CODE 95700: (62.46/34.6062) x 259.12 = 466.42
CODE 95716: (62.46/34.6062) X 1295.58 2332.04
2022 conversion factor:
DWC 62.46
Medicare 34.6062
Novitas participating amount for 95715 = 1036.46
Novitas participating amount for 95712 518.23
Novitas participating amount for 95700 = 259.12
Novitas participation amount for 95714 = 207.29
Novitas participation amount for 95718 = 134.85
Novitas participation amount for 95716 = 1295.58."
Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §134.1 sets forth general provisions related to medical reimbursement.
5. TLC §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- CAC-P12 WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Issues

1. Did the insurance carrier issue a payment in accordance with 28 TAC §134.203 for CPT code 95724?
2. Did the requestor respond to the request for additional documentation to support the fair and reasonable rate of reimbursement?
3. Did the insurance carrier issue a payment for CPT Codes 95700, and 95716 x 3, in accordance with 28 TAC §134.1?

Findings

1. The requestor seeks reimbursement for CPT Code 95724 rendered on December 27, 2022. The insurance carrier issued a payment in the amount of $606.15. The requestor seeks an additional payment of $770.85.

   28 TAC §134.203(b)(1) states, "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."

28 TAC §134.203 states in pertinent part, "(c) 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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bills, the services were rendered in zip code 77042; therefore, the Medicare locality is "Houston."
- The Medicare Participating amount for CPT code 95724 at this locality is $335.84.
- Using the above formula, the DWC finds the MAR is $606.15.
- The respondent paid $606.15.
- Additional reimbursement of $0.00 is recommended.

2. Since there is no DWC fee guideline and CPT codes 97500 and 95716 are not priced by Medicare, the DWC requested on June 12, 2023, that both parties submit documentation to support the fair and reasonable rate of reimbursement. As of right now, neither side has replied to the division. As a result, the documentation in the dispute at the time of the review serves as the basis for the decision.

3. The requestor seeks an additional payment for CPT codes 95700 and 95716.

CPT code 95700

- The requestor billed the insurance carrier $1,250.00 for CPT code 95700 rendered on December 27, 2022.
- The insurance carrier issued a payment in the amount of $466.42.
- The requestor seeks an additional payment of $783.58.

CPT code 95716

- The requestor billed the insurance carrier $14,429.00 for dates of service December 27, 2022, December 28, 2022, and December 29, 2022.
- The insurance carrier issued payments in the amount of $2,332.04 for each date of service.
- The requestor seeks an additional payment of $12,096.96 for each date of service.

The services in dispute are not priced by CMS; therefore, they are subject to the fair and reasonable reimbursement provisions of 28 TAC §134.1.

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."

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 did not submit a position statement specific to the disputed services, for consideration in this dispute.
- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor's position statement for increased reimbursement from the *Table of Disputed Services* asserts, "Designated doctor referred testing incorrect reduction."
- The requestor did not submit documentation to support a fair & reasonable reimbursement for the disputed services.
- The requestor does not discuss or explain how documentation submitted supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- 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.

The requestor has failed to meet the requirements of DWC rules and the Labor Code. The requestor has the burden of proof at MFDR to support their request for additional reimbursement by a preponderance of the evidence. DWC concludes the requestor provided insufficient information to meet that burden. Consequently, additional payment cannot be recommended for 95700, rendered on December 27, 2022 and 95716 rendered on December 27, 2022, December 28, 2022, and December 29, 2022.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that additional reimbursement of $0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 6, 2023 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.