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 Neurodiagnostic

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-0792-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
December 7, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 30, 2023	95700, 95716 x 3 and 95724	$37,355.36	$0.00
	Total	$37,355.36	$0.00

Requestor's Position

"DESIGNATED DOCTOR REFERRED TESTING INCORRECT REDUCTION."

Amount in Dispute: $37,355.36

Respondent's Position

"Texas Mutual maintains that payment was made in accordance with Medicare fee guidelines for Medicare region TX18, with Medicare markup of 1.9131 and conversion factor of 33.8872. Our position is that no additional payment is due."

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.1 sets out the medical reimbursement guidelines for fair and reasonable reimbursement.

Denial Reasons

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

- CAC P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC W3 & 350 – In accordance with TDI-DWC rule 134.804. this bill has been identified as a request for reconsideration or appeal.
- CAC 131 – Claim specific negotiated discount.
- DC3 – Additional reimbursement allowed after reconsideration.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- CAC 243 – Services not authorized by network/primary care providers.
- D27 – Provider not approved to treat WorkWell, TX network claimant.

Issues

1. Did the insurance carrier issue a payment for the disputed services?
2. Did the insurance carrier issue a payment for CPT code 95724 in accordance with 28 TAC §134.203?
3. Are CPT codes 95700 and 95716 x 3 subject to fair and reasonable reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the insurance carrier $45,914.00 for CPT codes 95700, 95716 x 3 and 95724 rendered on May 30, 2023. The insurance carrier issued a payment in the amount of $8,558.64 and reduced the remaining charges with denial reduction codes indicated above. The requestor seeks an additional payment in the amount of $37,355.36.

2. The insurance carrier issued a payment for CPT code 95724 in the amount of $627.14. The requestor seeks an additional payment in the amount of $749.86. The requestor's eligibility for an additional payment will be decided by the DWC.

   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 2023 DWC Conversion Factor is 64.83
   - The 2023 Medicare Conversion Factor is 33.8872
   - Per the medical bills, the services were rendered in 77042, TX; the Medicare locality is "Houston."
   - The Medicare Participating amount for CPT code 95724 at this locality is $327.81.
   - Using the above formula, the DWC finds the MAR is $627.14.
   - The requestor seeks $749.86.
   - The respondent paid $627.14.
   - The requestor is not entitled to additional reimbursement.

3. The requestor seeks an additional payment in the amount of $36,605.50 for CPT codes 95700 and 95716 rendered on May 30, 2023. The insurance carrier paid $7,931.50 and reduced the remaining charges with denial reason codes indicated above. The DWC finds that the disputed services are not valued by Medicare's physician fee schedule, and no documentation was included in the dispute to support a negotiated contract. As a result, the disputed services fall under the fair and reasonable provisions in 28 TAC §134.1

   This dispute pertains to services billed under CPT codes 95700 and 95716 with reimbursement subject to the general medical reimbursement provisions of 28 TAC §134.1. Rule §134.1(e) and (f) states, "

(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(1) the Division's fee guidelines;
(2) a negotiated contract; or
(3) 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.

(f) 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."

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 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**."**

Review of the submitted documentation finds that:

- The requestor's position statement states, "DESIGNATED DOCTOR REFERRED TESTING INCORRECT REDUCTION."
- The requestor did not submit documentation to support how the requested additional payment would ensure the quality of medical care and achieve effective medical cost control.
- The requestor does not discuss or explain how the requested additional payment would result in similar reimbursement that similar procedures provided in similar circumstances received.
- 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 request for additional reimbursement is not supported.

4. 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.

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.

DWC finds the requestor has not established that additional reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 5, 2024 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.