TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Robert Joseph Coolbaugh

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-24-0952-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
January 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2023	99080	$50.00	$0.00
	Total	$50.00	$0.00

Requestor's Position

"The requestor did not submit a position statement with this MFDR request."

Amount in Dispute: $50.00

Respondent's Position

"Our initial response to the above reference medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Supplemental response dated January 19, 2024.

"Our bill audit company has determined no further payment is due."

Response submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §129.5 sets out the billing requirements for work status reports.

3. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical claims.

4. 28 TAC §134.1 sets out the guidelines for fair and reasonable reimbursement.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 90950- This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes to the previous payment.
- 181 – Payment adjusted because this procedure code was invalid on the date of service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same date according.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of a special report for November 21, 2023 date of service. The insurance carrier denied the claim based lack of modifier.

   Review of the submitted documentation did not find a copy of the report requested by OIC on November 20, 2023. The requirement of DWC Rule 28 TAC §129.5 pertains to "Work Status Reports". Insufficient evidence was found to support what type of report was submitted to OIC and subsequently billed for reimbursement. The insurance carrier's denial is not supported.

   As the provisions of DWC Rule 129.5 did not apply, DWC Rule 28 TAC 134.203(h) states, When there is no negotiated or contracted amount that complies with Labor Code §413.011,

reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

Review of the Medicare and Medicaid fee schedule found no payment amount for code 99080 to establish the maximum allowable reimbursement (MAR). There was insufficient evidence to support a negotiated contract. The provisions of fair and reasonable reimbursement is found below.

DWC Rule 28 TAC §134.1. §134.1(e) (3) and (f) states, "(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(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."

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 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."

DWC Rule 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**."**

Review of the submitted documentation finds that:

- The requestor did not submit documentation to support how the requested payment would ensure the quality of medical care and achieve effective medical cost control.
- The requestor does not discuss or explain how the requested 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 reimbursement is not supported.

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, payment cannot be recommended.

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 requester has not established that reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 6, 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 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.