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
HIGHPOINT PHARMACY

Respondent Name
ARROWOOD INDEMNITY COMPANY

MFDR Tracking Number
M4-04-0700-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
September 12, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DME Ground Rules Selection VII. states to use the miscellaneous HCPCS Code E1399 when no other Code is present."

Amount in Dispute: $64.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2002	Primapore Wound Dressing	$64.05	$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 §133.300 sets out rules regarding insurance carrier receipt of medical bills.
3. 28 Texas Administrative Code §133.1 defines words and terms related to medical benefits.
4. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
5. 28 Texas Administrative Code §134.201 adopts by reference the Texas Workers' Compensation Commission Medical Fee Guideline 1996.
6. Texas Workers' Compensation Commission Medical Fee Guideline 1996 sets out the fee guidelines for medical services rendered on or after April 1, 1996.
7. Texas Workers' Compensation Commission Medical Fee Guideline 2d Edition 1991 sets out the fee guidelines for medical treatments, services, and durable medical equipment provided prior to April 1, 1996.
8. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
9. The insurance carrier returned the bill for disputed services with explanation noted:
   - Please resubmit with valid CPT Codes. – E1399 – no good
   - Need proper codes

Findings

1. The insurance carrier returned the medical bill for disputed services without processing for payment, indicating as explanation "Please resubmit with valid CPT Codes. – E1399 – no good" and "Need proper codes." Per 28 Texas Administrative Code §133.300(c), effective July 15, 2000, 25 *Texas Register* 2115 "Upon receipt, an insurance carrier shall evaluate each medical bill for completeness as defined in §133.1 of this title (relating to Definitions for Chapter 133, Benefits--Medical Benefits). (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill." Per 28 Texas Administrative Code §133.1(a)(1)(C), effective July 15, 2000, 25 *Texas Register* 2115, a complete medical bill "includes correct billing codes from Commission fee guidelines in effect on the date(s) of service." Review of the submitted documentation finds that the health care provider submitted a medical bill for durable medical supplies with reimbursement subject to the provisions of former Division rule at 28 Texas Administrative Code §134.201, which adopted by reference the Texas Workers' Compensation Commission [now the Division] Medical Fee Guideline 1996, in which the Durable Medical Equipment (DME) Ground Rules Section IV. Nonlisted Items and Documentation of Procedure, instructs the provider to "Use the miscellaneous HCPCS code E1399, when no other HCPCS code is present for the DME or supplies provided to the injured worker. When using E1399, a description of the unlisted equipment/supply is required." Accordingly, the Division finds that the medical bill included correct billing codes from Division fee guidelines in effect on the date of service. The bill therefore met the correct coding requirement of §133.1(a)(1)(C) necessary to qualify as a complete medical bill. Consequently, the insurance carrier's rationale for returning the bill is unsupported and the carrier has not met the requirement of §133.300(c)(1). The Division concludes that the insurance carrier's return of the complete medical bill was inappropriate. The services will therefore be reviewed for reimbursement in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to durable medical supplies with reimbursement subject to the provisions of former Division rule at 28 Texas Administrative Code §134.201, which adopted by reference the Texas Workers' Compensation Commission [now the Division] Medical Fee Guideline 1996. Per Medical Fee Guideline 1996 Durable Medical Equipment (DME) Ground Rules Section IV. Nonlisted Items and Documentation of Procedure, "the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. Use the miscellaneous HCPCS code E1399, when no other HCPCS code is present for the DME or supplies provided to the injured worker. When using E1399, a description of the unlisted equipment/supply is required." Subsection C. further provides that "A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline." Review of the submitted documentation finds not information to support a pre-negotiated amount between the parties to this dispute; therefore, the insurance carrier shall reimburse the DME provider at the fair and reasonable rate for the items described. Review of the Division's former 1991 Medical Fee Guideline 2nd Edition Durable Medical Equipment (DME) Ground Rules finds no 'D' code listed for a primapore woundcare dressing; therefore, the applicable rule for determination of reimbursement is the Divisions former version of 28 Texas Administrative Code §134.1(c) regarding reimbursement for services not identified in an established fee guideline.
3. This dispute relates to items subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. 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.
5. Former 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
6. Former 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds no explanation of the requestor's reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).

7. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, 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." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - 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 the requestor in this dispute is not a hospital, the above principle similarly applies. A health care provider's usual and customary charges, in and of themselves, 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 billed charges is not acceptable because it leaves the ultimate reimbursement in the control of the health care provider, which ignores 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 when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish 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 services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	April 4, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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