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 RESOLTUION FINDINGS AND DECISION*

**Requestor Name**
COBIA MEDICAL

**Respondent Name**
CITY OF SAN ANTONIO

**Carrier's Austin Representative**
Box Number 19

**MFDR Tracking Number**
M4-04-7460

**MFDR Date Received**
March 12, 2004

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Letter of medical necessity enclosed for post-op patient. The pymt of 256.25 is not considered reasonable, especially when Medicare at that time reimburses at $983.00 for the same brace. I've enclosed invoice and data & wish to collect additional payment of at least $700 to $800 please."

**Amount in Dispute:** $963.75

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Harris & Harris represents the City of San Antonio in this matter. Please direct all future correspondence regarding this Medical Dispute matter to the undersigned at Harris & Harris."

**Response Submitted by:** Harris & Harris

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 12, 2003 and December 17, 2003 | L0976 and L0565 | $963.75 | $0.00 |

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. Former 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §133.304, sets out the guidelines for Medical Payments and Denials.
3. Former 28 Texas Administrative Code §133.308 adopted to be effective January 2, 2002, sets out the procedure for resolving medical necessity disputes, by an Independent Review Organization.
4. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. This request for medical fee dispute resolution was received by the Division on March 12, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, the Division notified the requestor on March 19, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - U – Payment is denied because the treatment/service is medically unreasonable and/or unnecessary. This is not based on a peer review
   - M – Maximum allowable reimbursement

## Issues

1. Did the requestor file the dispute pursuant to 28 Texas Administrative Code §133.305 and §133.307?
2. Did the requestor submit sufficient documentation to support fair and reasonable reimbursement for date of service 3/12/2003?

## Findings

1. The requestor seeks reimbursement for HCPCS Code L0976, rendered on December 17, 2003. The insurance carrier denied the disputed services with denial code:

    - U – Payment is denied because the treatment/service is medically unreasonable and/or unnecessary. This is not based on a peer review.

    The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on March 12, 2004, the disputed services were denied/reduced by the insurance due to unresolved medical necessity. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination.

    Former 28 Texas Administrative Code §133.308 (a)(1) states, "(1) This rule applies to the independent review of prospective or retrospective medical necessity disputes (a review of health care requiring preauthorization or concurrent review, or retrospective review of health care provided) for which the initial dispute resolution request was filed on or after January 1, 2002. Dispute resolution requests filed prior to January 1, 2002 shall be resolved in accordance with the rules in effect at the time the request was filed. All independent review organizations (IRO's) performing reviews of health care under the Texas Workers' Compensation Act (the Act), regardless of where the independent review activities are based, shall comply with this rule."

    Former 28 Texas Administrative Code §133.308 (e) (1) "Timeliness. A person or entity who fails to timely file a request waives the right to independent review or medical dispute resolution. The commission shall deem a request to be filed on the date the division and the carrier receive the initial request, and timeliness shall be determined as follows: (1) A request for retrospective necessity dispute resolution of a medical bill pursuant to §133.304, of this title (relating to Medical Payments and Denials), shall be considered timely if it is filed with the carrier and the division no later than one (1) year after the date(s) of service in the dispute..."

    Former 28 Texas Administrative Code §133.308 (f) states, "(f) Initial Request (General). A request for independent review must be filed in the form, format, and manner prescribed by the commission. Each request shall be legible, shall include only a single copy of each document, and shall include: (1) a designation that the request is for review by Independent Review Organization; (2) written notices of adverse determinations (both initial and reconsideration) of prospective or retrospective necessity disputes, if in the possession of the requestor; (3) documentation of the request for and response to reconsideration, or, if the respondent failed to respond to a request for reconsideration, convincing evidence of carrier receipt of that request.."

    Former 28 Texas Administrative Code §133.308 states, "(4) for medical necessity disputes: (A) for retrospective necessity disputes, a table of disputed health care denied for lack of medical necessity, which includes complete details of the dispute issues (denial codes T, U or V) in accordance with §133.304..."

    The division notified the requestor of the unresolved medical necessity issue on October 21, 2013. Review of the documentation contained in the dispute supports that the requestor did not respond to the notification letter mailed on October 21, 2013. As a result, due to no action taken by the requestor after the notification letter, the Division finds that good cause exists to dismiss the request for medical dispute resolution for HCPCS Code L0976, rendered on December 17, 2003.

    Per 28 Texas Administrative Code §133.307(m) (6), "Dismissal. A dismissal does not constitute a decision. The division may dismiss a request for medical fee dispute resolutions if... (6) the division determines that good cause exists to dismiss the request." The division finds that good cause exists to dismiss the request for medical fee dispute resolution.

2. The requestor seeks additional reimbursement for HCPCS Code L0565 rendered on March 12, 2003. Review of the submitted documentation supports that the insurance carrier issued a payment in the amount of $256.25 and the requestor seeks an additional payment of $818.75. The insurance carrier reduced the disputed charge with reduction code "M – Maximum allowable reimbursement."

    The charge for HCPCS Code L0565 relates to a service with reimbursement 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."

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.

Former 28 Texas Administrative Code §133.307(g) (3) (D), effective January 1, 2003, 27 *Texas Register* 12282, 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's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "...256.25 is not considered reasonable, especially when Medicare at that time reimburses at $983.00..."
- The requestor does not discuss or explain how the Medicare reimbursement rate, supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
- The requestor submitted insufficient documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- Documentation of the comparison of charges to other carriers was not presented for review.
- The requestor submitted insufficient 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 | Medical Fee Dispute Resolution Officer | March 15, 2017<br>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**.