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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HIGHPOINT PHARMACY

Respondent Name
SENTRY INSURANCE A MUTUAL COMPANY

MFDR Tracking Number
M4-04-A552-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
June 29, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the treating doctor has stated these items are related to the patient's injuries, the Carrier should be responsible for payment."

Amount in Dispute: $393.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I have attached evidence of payment on these service dates."

Response Submitted by: Sentry Claims Service, PO Box 29466, Phoenix, Arizona 85038

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2003 to August 13, 2003	Durable medical supplies and pharmaceuticals	$393.17	$19.10

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 §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - E – Entitlement to benefits
   - M – No MAR
   - 1 – Charge for this procedure exceeds average wholesale price plus mark-up. (Z650)
   - N – Not Documented
   - F – Fee Guideline MAR Reduction
   - 1 – For the billed services to be reviewed, please submit a HCPCS code listed in the state fee schedule. (X912)

- 2 – This charge has been reimbursed according to the appropriate fee schedule or usual and customary value. (Z651)
- 3 – The charge for this procedure exceeds the fee schedule or usual and customary allowance. (Z560)

Findings

1. The insurance carrier originally denied disputed services with payment exception code E – "Entitlement to benefits." However, after the parties reached mutual agreement regarding compensability and entitlement to benefits, the insurance carrier reconsidered the charges for the disputed services and did not maintain this denial reason upon final action. The Division concludes that there are no unresolved issues of entitlement or compensability related to the services in this dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Subsequent to the filing of this medical fee dispute, the insurance carrier reconsidered the charges for disputed services and has issued additional payments. Following receipt of additional insurance carrier payments, the requestor submitted an amended Table of Disputed Services for consideration in this dispute. The Division will consider the disputed services as indicated in the requestor's amended table as the basis for this review.
3. For service date August 1, 2003, The requestor billed the carrier for a fifteen day supply of Carisoprodol 350 mg, quantity dispensed 45, for a billed amount of $158.20. The insurance carrier paid $138.46. Per §134.503(a), effective January 3, 2002, 26 Texas Register 10970, "The maximum allowable reimbursement (MAR) for prescription drugs shall be the lesser of: (1) The provider's usual and customary charge for the same or similar service; (2) The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed. (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = MAR; (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee = MAR; (C) A compounding fee of $15 per compound shall be added for compound drugs; or (3) A negotiated or contract amount." No documentation was found to support a negotiated or contract amount applicable to the disputed prescription drug. Review of the submitted information finds no documentation of the health care provider's usual and customary charge for the disputed prescription drug. No documentation was presented to support an average wholesale price. In the absence of the above information, the Division is unable to determine the lesser amount. The requestor has the burden of proof to establish by a preponderance of the evidence that additional reimbursement is due. The requestor has failed to support that additional reimbursement is due for the disputed prescription drug. Additional reimbursement cannot be recommended.
4. The insurance carrier denied disputed services with payment exception code N – "Not Documented"; with additional comment "For the billed services to be reviewed, please submit a HCPCS code listed in the state fee schedule. (X912)" 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 insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
5. 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." 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 no 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 'D' codes listed for the following disputed items:
    - Item E1399, date of service July 7, 2003, described as SURGICAL TAPE 1" ROLL is listed in the 1991 Medical Fee Guideline under D0325 Surgical tape per roll. The fee set for this code is $5.00. Per Medical Fee Guideline 1996 Durable Medical Equipment (DME) Ground Rules Section IV, the Division concludes that the listed fee is a fair and reasonable price for the item in dispute.

The recommended reimbursement is $5.00.

- Item E1399, date of service July 7, 2003, described as ALOE LOTION/LNMT/CRM/GEL 8 0Z is listed in the 1991 Medical Fee Guideline under D0306 Cleaners, gel, ointments. The fee set for this code is $14.10. Per Medical Fee Guideline 1996 Durable Medical Equipment (DME) Ground Rules Section IV, the Division concludes that the listed fee is a fair and reasonable price for the item in dispute. The recommended reimbursement is $14.10.

No comparable "D" code was found listed in the Division's former 1991 Medical Fee Guideline 2nd Edition Durable Medical Equipment (DME) Ground Rules for the following disputed items:

- Item E1399, date of service July 7, 2003, described as WOUND CLOSURE OPSITE 7X3.25
- Item E1399, date of service July 7, 2003, described as WOUND DRESSING PRIMAPORE 8X4
- Item E1399, date of service July 7, 2003, described as 4X4 STERILE GAUZE

As these three items are not identified in an established fee guideline, the applicable rule for reimbursement is the Division's former version of 28 Texas Administrative Code §134.1 regarding use of the fee guidelines.

6. 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, 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."
7. 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.
8. 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 for disputed items E1399, date of service July 7, 2003, WOUND CLOSURE OPSITE 7X3.25; E1399, date of service July 7, 2003, WOUND DRESSING PRIMAPORE 8X4; and E1399, date of service July 7, 2003, 4X4 STERILE GAUZE 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 for these three items cannot be recommended.
9. The Division concludes that reimbursement is recommended for Item E1399, date of service July 7, 2003, SURGICAL TAPE 1" ROLL; and E1399, date of service July 7, 2003, ALOE LOTION/LNMT/CRM/GEL 8 0Z. The total recommended reimbursement is $19.10. The insurance carrier paid $0.00, leaving an amount due to the requestor of $19.10.

Conclusion

For the reasons stated above, the requestor has established that additional reimbursement is due. As a result, the amount ordered is $19.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $19.10 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

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