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
ACCESS MEDIQUIP

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-09-4870-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 6, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HCPCS code L9900 and L8689 were denied as a bundled charges. The codes are for miscellaneous and non-miscellaneous items and should not be bundled or denied based on the HCPCS Code L8680 for the sixteen electrodes billed for the dual a array pulse generator. Access Mediquip, L.L.C. incurs a separate cost for these items and theses devices are used in conjunction with the electrodes."

Amount in Dispute: $1,526.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon further review, Texas Mutual will reimburse the requestor the disputed amount plus applicable interest for code L8689. . . . Code L9900, is the accessory kit with antenna/connector. It s this carrier's position that no reimbursement is due for these supplies associated with the implantable pulse generator as reimbursement for these supplies is included in the implantable pulse generator."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2008	Durable Medical Equipment	$1,526.08	$40.48

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 medical reimbursement.
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:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.

- W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.

Issues

1. What is the recommended payment amount for procedure code L8689?
2. What is the recommended payment amount for procedure code L9900?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to durable medical equipment with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202, effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided" with any additions or exceptions as set forth in the rule. Subsection 134.202(c) requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: . ,. . (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule." With respect to disputed equipment billed under procedure code L8689, service date July 23, 2008, the respondent's position statement agrees that the requested balance is due, stating "Upon further review, Texas Mutual will reimburse the requestor the disputed amount plus applicable interest for code L8689." Review of the submitted information finds that the insurance carrier's denial reasons are not supported. Accordingly, reimbursement is calculated according to the July 2008 Medicare DMEPOS rate of $1,498.34 multiplied by 125% for a MAR of $1,872.93. The requestor is seeking reimbursement of $40.48. This amount is recommended.
2. 28 Texas Administrative Code §134.202(c)(2) requires that " (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection." §134.202(c)(6) further requires that "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." No documentation was found to support a negotiated or contracted amount applicable to the disputed services. Procedure code L9900, service date July 23, 2008, does not have a fee listed in the Medicare DMEPOS fee schedule, nor does it have a fee listed in the Texas Medicaid fee schedule. This code represents a product for which neither CMS nor the Division has established a relative value unit and/or a payment amount. No documentation was found to support that the carrier has assigned a relative value in accordance with §134.202(c)(6). Reimbursement is therefore calculated according to 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."

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "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. 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(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the 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), as applicable." Review of the submitted documentation finds that:

- The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that the requested reimbursement of $1,485.60 represents "(FEE x 20%)"
- The requestor did not submit documentation to support a base fee amount.
- The requestor does not discuss or explain how "(FEE x 20%)" supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this 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 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 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.

4. The total recommended payment for the services in dispute is $40.48. The respondent's position statement asserts that "Texas Mutual will reimburse the requestor the disputed amount plus applicable interest for code L8689. Payment to the requestor will follow under separate cover." However, no documentation was found to support that the respondent has since issued payment of the disputed amount. By facsimile transmission dated March 19, 2009, the requestor informed the Division that additional payment has not been received. Review of the submitted information finds that the insurance carrier has paid $0.00, leaving an amount due to the requestor of $40.48. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $40.48.

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 $40.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 6, 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.