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 and Address

FIRST HOME HEALTH
2809 S EXPRESSWAY 83
HARLINGEN TX 78550-7613

Respondent Name
LIBERTY MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-05-1689-01

MFDR Date Received
November 2, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "ALL APPROPRIATE STEPS & PROCEDURES WERE FOLLOWED WITH CONTACTING PRE CERT DEPT AND ADJUSTER BUT NO ONE RETURNED MY CALLS. Ms. AliCIA RAMOS, INS CASE MGR GAVE APPROVAL AS PER INS. (VERBAL APPROVAL."

Amount in Dispute: $8,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the adjuster made an agreement – after the fact – to pay $8500. The provider indicates that the NCM . . . approved the work to be completed. . . . [the NCM] has stated that she did not give approval for the work and, in fact did not have authority to do so."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2004	Home Modifications	$8,500.00	$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 §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:
   - Z560 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY INGENIX. (Z560)
   - Z789 – REIMBURSEMENT REFLECTS NEGOTIATED DISCOUNT. (Z789)
   - X375 – UNNECESSARY MEDICAL TREATMENT OF SERVICE. (X375)

Issues

1. Are there unresolved issues of medical necessity?
2. Are the services subject to a negotiated discount or contractual fee agreement?
3. What is the applicable rule for reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied procedure code 99199, service date February 3, 2004, billed in the amount of $3,800.00 with reason code X375 – "UNNECESSARY MEDICAL TREATMENT OF SERVICE." Per 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines)." Per 28 Texas Administrative Code §133.307(g)(2), effective January 1, 2003, 27 *Texas Register* 12282, "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution, therefore this disputed service will not be considered in this review.
2. The insurance carrier denied or reduced disputed services with reason code Z789 – "REIMBURSEMENT REFLECTS NEGOTIATED DISCOUNT." Review of the submitted information finds no documentation to support a negotiated discount or contractual fee agreement between the parties to this dispute. This reason code is not supported. Therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.
3. This dispute relates to services 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.
4. 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 has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how the submitted documentation 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 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	[redacted] Medical Fee Dispute Resolution Officer	January 16, 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.