



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

MARK R BRINKER, MD

**Respondent Name**

TRAVELERS INDEMNITY COMPANY

**MFDR Tracking Number**

M4-10-2335-01

**Carrier's Austin Representative**

Box Number 5

**MFDR Date Received**

January 4, 2010

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "not paid according to the fee schedule."

**Amount in Dispute:** \$56.99

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier has reviewed the reimbursement calculations, and confirmed the Provider was properly reimbursement under the terms of the contract."

**Response Submitted by:** Travelers

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2009	Procedure Code 99244	\$ 56.99	\$56.99

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - AFFL – 45 - CHARGE EXCEEDS FEE SCH/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THIS BILL HAS BEEN REVIEWED/REPRICED IN ACCORDANCE WITH FEE FOR SVC CONTRACT WITH FIRST HEALTH. ANY QUESTIONS, VISIT WEBSITE AT [WWW.FIRSTHEALTH.COM](http://WWW.FIRSTHEALTH.COM).
  - Z024– 45 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE DIFFERENCE BETWEEN THE FEE SCHEDULE AMOUNT AND THE AMOUNT PAID IS YOUR PPO DISCOUNT.

## Issues

1. Are the disputed services subject to a contracted fee agreement between the parties to this dispute?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The insurance carrier reduced payment for disputed services with reason codes AFFL – "45 - CHARGE EXCEEDS FEE SCH/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THIS BILL HAS BEEN REVIEWED/REPRICED IN ACCORDANCE WITH FEE FOR SVC CONTRACT WITH FIRST HEALTH. ANY QUESTIONS, VISIT WEBSITE AT WWW.FIRSTHEALTH.COM."; and Z024– "45 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE DIFFERENCE BETWEEN THE FEE SCHEDULE AMOUNT AND THE AMOUNT PAID IS YOUR PPO DISCOUNT." Review of the submitted information found no documentation to support that the disputed services are subject to a contracted fee arrangement between the parties to this dispute. Nevertheless, on January 22, 2010, the Division requested the respondent to provide documentation to support the contractual payment adjustments in accordance with Labor Code Sec. 413.011(d-3), which states, in pertinent part, that:

An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . Notwithstanding Subsection (d-1) or Section 1305.153, Insurance Code, the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: . . .

(3) does not:

- (A) clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the named insurance carrier's authorized agent; or
- (B) comply with the notice requirements under Subsection (d-2)."

Subsection (d-1) requires that:

If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a contractual arrangement between:

- (1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers on the carrier's behalf; and
- (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements established under Subsection (d-2).

Subsection (d-2) further requires that:

An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by commissioner rule.

Review of the submitted information finds no documentation to support a contractual arrangement between the carrier or authorized agent and the alleged informal or voluntary network that authorizes the network to contract with health care providers on the carrier's (Travelers') behalf in accordance with Subsection (d-1)(1). No documentation was found to support notice to the health care provider that Travelers had been given access to the network's fee arrangements with the health care provider in accordance with Subsections (d-2), (d-1)(2), and (d-3)(3)(B). Review of the submitted information finds no documentation that clearly states that the contractual fee arrangement is between the health care provider and the named insurance carrier (Travelers) or the named insurance carrier's authorized agent in accordance with Subsection (d-3)(3)(A). The Division therefore finds that the insurance carrier's payment reduction reason is not supported. Consequently, the Division concludes that the insurance carrier may not pay fees that are inconsistent with the Division's fee guidelines. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for calendar year 2009 is \$53.68. Reimbursement

is calculated as follows:

- Procedure code 99244, date of service June 3, 2009, performed in Houston Texas, has a Medicare payment rate of 187.06. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division's conversion factor of \$53.68, results in a MAR of \$278.41.
3. The total recommended payment for the services in dispute is \$278.41. This amount less the amount previously paid by the insurance carrier of \$221.42 leaves an amount due to the requestor of \$56.99. 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 \$56.99.

**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 \$56.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

Grayson Richardson  
Medical Fee Dispute Resolution Officer

October 17, 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.**