



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

MICHAEL CHRISTOPHER MAIER

Respondent Name

AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number

M4-11-0318-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "suggested and paid amount of \$233.83 is below the fee schedule."

Amount in Dispute: \$123.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has determined that the correct reimbursement rate, and the rate consistent the applicable fee guidelines, is \$233.83. No additional reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2009 to November 24, 2009	Procedure Code J7322	\$123.51	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.4 provides for written notification to health care providers of contractual agreements for informal and voluntary networks.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
- 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:
 - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT
 - PAE – AETNA PROCESS COMPLETE. NO REDUCTIONS RECOMMENDED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?

Findings

1. The insurance carrier denied disputed services with reason codes 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT"; and PAE – "AETNA PROCESS COMPLETE. NO REDUCTIONS RECOMMENDED." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 21, 2011, the Division requested the respondent to provide a copy of the referenced contract between the provider and the alleged network, a copy of the contract between the insurance carrier American Zurich Insurance Company and the alleged network, as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the contracted fee arrangement. The respondent acknowledged receipt of the request for additional information on September 22, 2011; however, no additional information was submitted for review. The insurance carrier's denial reasons are not supported. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will 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 for professional services, system participants shall apply the Medicare payment policies with minimal modifications." Per §134.203(f), "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." Review of the 2009 Medicare Physician Fee Schedule finds that no relative value unit or payment has been assigned by Medicare for disputed procedure code J7322. Neither is any code assigned by Medicaid as set forth in §134.203(d). Consequently, reimbursement shall be provided in accordance with §134.1.
28 Texas Administrative Code §134.1(f), effective March 1, 2008, 33 *Texas Register* 626, 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.
3. 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 did not submit a position statement for consideration in this dispute.
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
 - The requestor's table of disputed services asserts that the Medical Fee Guideline MAR for the disputed services is \$304.52; however, the requestor did not submit documentation to support that the Medical Fee Guideline MAR is \$304.52.
 - 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.

Conclusion

For the reasons stated above, the Division finds that 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

	Grayson Richardson	August 7, 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.