TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Midland Memorial Hospital

**Respondent Name**
American Zurich Insurance Co

**MFDR Tracking Number**
M4-20-1284-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
January 22, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per the TDI/DWC fee schedule this account qualifies for an Outlier payment…"

**Amount in Dispute:** $4,073.32

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "It is the carrier's position that the provider is not entitled to any additional reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson"

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 29, 2019 | Outpatient hospital services | $4,073.32 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

**Issues**

Is the insurance carrier's payment per fee guideline?

**Findings**

The requestor is seeking additional reimbursement for outpatient hospital services rendered May 29, 2019 in the amount of $4,073.32 as the requestor believes the claim qualifies for an outlier payment.

While 28 TAC 134.403 (f) does allow for outlier payment, section (d) requires the requestor to comply with Medicare payment policies.

The Medicare payment policy regarding outliers is found at www.cms.gov, Claims processing Manual Chapter Four, Section 10.7 and states, "the total cost for a service **exceeds** 1.75 times the OPPS payment **and separately** exceeds the fixed-dollar threshold determined each year."

Based on the applicable DWC fee guideline the medical bill is reviewed as follows:

| Procedure Code | Cost | OPPS payment x 1.75 | Fixed Dollar Threshold for 2019 | Outlier criteria met? |
|---|---|---|---|---|
| 99284 | $40.50 | $360.37 x 1.75 = $630.65 | $4,150.00 | Cost meets neither criteria |
| Composite APC 8006 | $3,160.30 | $480.77 x 1.75 = $841.35 | $4,150.00 | Only one of the criteria met. |

Based on the above, no additional payment is due.

**Conclusion**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 26, 2020<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.