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
VISTA MEDICAL CENTER HOSPITAL

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE CO

MFDR Tracking Number
M4-06-5061-02

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 7, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "W-10-Carrier did not make 'fair and reasonable' reimbursement and did not make consistent reimbursement…W1-Code used incorrectly for charge for which no "MAR' has been established."

Amount in Dispute: $3,472.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 20, 2006: "We have received the medical dispute filed by Vista Medical Center for services rendered to [Claimant] on date of service 9/12/05. The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same…Liberty Mutual does not believe that Vista Medical Center is due any further reimbursement."

Response Submitted by: Liberty Mutual Insurance

Respondent's Supplemental Position Summary Dated July 30, 2014: "This dispute actually revolves around the Provider's contention it is owed additional monies for facility fees delivered incident to an outpatient procedure. Parties came to an agreement on this dispute o September 8, 2013, a copy of which is attached hereto. No matters remain in controversy at this time.

Responses Submitted by: Hanna & Plaut L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2005	Outpatient Hospital Services	$3,472.59	$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 §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
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:
   - W1-Workers compensation state fee schedule adjustment.
   - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - Z601-The charge exceeds usual and customary.
5. Dispute M4-06-5061 History
   - Dispute was originally decided on November 20, 2006.
   - The original dispute decision was appealed to District Court.
   - District Court remanded the dispute to the Division pursuant to an agreed order of remand, cause number D-1-GN-06-004695, dated January 30, 2012.
   - Because of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
   - M4-06-5061-02 is hereby reviewed

Findings

1. This dispute relates to outpatient hospital services with reimbursement subject to 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."
2. 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. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, 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's position statement asserts that "Carrier did not make 'fair and reasonable' reimbursement and did not make consistent reimbursement."
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - 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 the requested alternative reimbursement methodology 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

		09/25/14
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.