TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Plains Memorial Hospital

Respondent Name
Guideone Mutual Insurance Co

MFDR Tracking Number
M4-15-1446

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are a Critical Access Hospital and use the Method II CAH billing. With this billing, we are allowed to bill the Professional services on a UB04."

Amount in Dispute: $206.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent respectfully submits that requestor has not offered compelling date to support that reimbursement was not fair and reasonable, or that billing, when performed in alignment with Rule 133.20(d)(2), would have given an appropriate basis for additional reimbursement."

Response Submitted by: Parker & Associates L.L.C

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2014	Critical Care Access Hospital Services	$206.00	$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 §134.1 sets out reimbursement guidelines for workers compensation medical claims.
3. The insurance carrier reduced/denied the disputed services with the following reason codes:
    - 193 – Original payment decision maintained
    - P12 – Workers' compensation state fee schedule adj
    - RN – Not paid under OPPS: services included in APC rate

- 981 – Professional fees must be submitted on a cms-1500

Issues

What rule is applicable to reimbursement?

Findings

The requestor is seeking additional reimbursement of services rendered in a Critical Care Access Hospital.

Under the division's general reimbursement Rule at 28 TAC §134.1(e), payment for health care is calculated by applying a fee from an adopted Division rule or by applying a negotiated contract rate. In the absence of an applicable fee guideline or a negotiated contract, the payment is subject to the division's general fair and reasonable requirements described in 28 TAC 134.1 (f) found below.

There is no DWC fee guideline for services provided in a Critical Care Hospital. No evidence of a contract was submitted. The DWC general fair and reasonable standard of payment applies to the disputed services.

28 TAC 134.1(f) required the health care provider to support their suggested reimbursement is consistent with the criteria of Labor Code §413.011 which requires documentation of similar procedures provided in similar circumstances received similar reimbursement; and their suggested reimbursement is 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.

Review of the submitted positiona statement did not meet the criteria described above.

No additional reimbursement is recommended.

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

		July 17, 2020
Signature	Medical Fee Dispute Resolution Officer	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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 Texas Administrative Code §141.1(d).

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