



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

UT HEALTH PITTSBURG

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-3993-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 29, 2019

Response Submitted By

Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

[The requestor did not submit a position statement for consideration in this review.]

RESPONDENT'S POSITION SUMMARY

"Medicare's reimbursement method of CAH's is based on nationally recognized studies and/or values assigned for services involving similar work and resource commitments. ... Medicare assigns a per diem amount to each CAH to be used for payment of acute inpatient services."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 18, 2018	Critical Access Hospital Services	\$276.12	\$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.404 sets out the hospital facility fee guideline for inpatient services.
- 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 225 – PLEASE PROVIDE THE FACILITY'S PART A PER DIEM WITH EFFECTIVE DATE.
 - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
 - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
 - P5 - BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT
 - W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
 - 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
 - 426 – REIMBURSED TO FAIR AND REASONABLE.

Issues

1. What is the applicable rule for determining reimbursement of Critical Access Hospital Services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards payment for inpatient services provided in a critical access hospital.

Per Medicare payment policies, critical access hospitals serve rural and low-population areas. Critical access hospitals are not reimbursed using Medicare's Inpatient Prospective Payment System (IPPS). Medicare instead reimburses such services according to provisions that have not been adopted by the Texas Division of Workers' Compensation (DWC) as the basis for reimbursement under any fee guideline.

DWC's *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404(f) determines reimbursement applying Medicare's IPPS formula and factors. This hospital's National Provider Identifier (NPI) number (field 56 on the bill) identifies the facility as a Critical Access Hospital; as a result, reimbursement cannot be determined by applying the formula in Rule §134.404(f). No information was found to support a contracted fee schedule or negotiated rate. Therefore, in the absence of an applicable fee schedule, Rule §134.404(e)(3) requires payment be determined according to Rule §134.1, regarding a fair and reasonable reimbursement.

2. This dispute regards critical access hospital services with reimbursement subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1.

Rule §134.1(f) requires 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.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 South Western Reporter Third 643, 656 (Texas 2004).

Additionally, the Third Court of Appeals held in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 South Western Reporter Third 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach ... reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

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.

28 Texas Administrative Code §133.307(c)(2)(O) 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 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) or reimbursement rate, as applicable

Review of the submitted information finds the requestor did not include a position statement with their request. Nor did the requestor provide any documentation to discuss, demonstrate or justify that the payment they are seeking is a fair and reasonable rate of reimbursement in accordance with Rule §134.1. The requestor has thus failed to meet the requirements of division rules and the Labor Code.

The requestor has the burden of proof at MFDR to support their request for additional reimbursement by a preponderance of the evidence. The division concludes the requestor provided insufficient information to meet that burden. Consequently, additional payment cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division 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 stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 24, 2019
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.

A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWCO45M) in accordance with the form’s instructions. The division must receive the request within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 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.