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
M4-19-3996-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 30, 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

"Medical audit staff processed the appeal and paid the bill in accordance with OPPS fee guidelines for outpatient services … Rev 450/99285 is status J2."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 7, 2018 to November 8, 2018	Critical Access Hospital services	$1,750.04	$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

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 hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - DC3 - ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.

- 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
- 246/219 – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. FINAL ADJUDICATION HAS NOT TAKEN PLACE.
- 746/P12 – ROUTINE DRUG TESTS FOR EMPLOYER & AS PART OF EMPLOYER POLICY ARE NOT MEDICALLY NECESSARY FOR THE TREATMENT OF THE COMPENSABLE INJURY.
- 219 – BASED ON EXTENT OF INJURY.

Issues

1. Are there any unresolved issues of extent of injury?
2. Are there any unresolved issues of medical necessity?
3. What is the applicable rule for determining reimbursement of Critical Access Hospital Services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
   - 246/219 – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. FINAL ADJUDICATION HAS NOT TAKEN PLACE.
   - 219 – BASED ON EXTENT OF INJURY.

   The insurance carrier did not maintain this denial reason upon appeal. After reconsideration, the carrier issued payment. Accordingly, the division finds there are no outstanding issues of extent of injury.

2. The insurance carrier denied disputed services with claim adjustment reason code:
   - 746/P12 – ROUTINE DRUG TESTS FOR EMPLOYER & AS PART OF EMPLOYER POLICY ARE NOT MEDICALLY NECESSARY FOR THE TREATMENT OF THE COMPENSABLE INJURY.

   The insurance carrier did not maintain this denial reason upon appeal. After reconsideration, the carrier issued payment. Accordingly, the division finds there are no outstanding issues of medical necessity.

3. This dispute regards payment for outpatient 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 Outpatient Prospective Payment System (OPPS) but are instead subject to special reimbursement 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*, Rule §134.403(f) determines reimbursement applying Medicare's OPPS 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 §134.403(f). No information to support a contracted fee schedule or negotiated rate was found in the submitted materials. Accordingly, Rule §134.403(e)(3) requires that in the absence of an applicable fee schedule, if payment cannot be determined using the formula in Rule §134.403(f), then payment is determined according to Rule §134.1, regarding a fair and reasonable reimbursement.

4. 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

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 the requestor has not established that additional payment 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 31, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.