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
Baptist St Anthonys Hospital

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-5319-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted

Amount in Dispute: $133.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Out of good faith the Office requested an immediate re-audit of the dates of service in dispute to allow payment for the disputed charges in accordance with all Division rules and payment policies."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2018	97161-GP	$133.39	$133.39

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 reimbursement policies for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the disputed services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 886 – The procedure was inappropriately billed
    - B16 – Payment adjusted because new patient qualifications were not met
    - 29 – The time limit for filing has expired

Issues

1. Is the respondent's position supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking for outpatient physical therapy services rendered in October 2018. The respondent stated in their position statement a payment was being allowed. Insufficient evidence was found to support a payment was made to date. The service in dispute will be reviewed per applicable fee guideline.

2. 28 TAC 134.403 applies to outpatient medical bills and section (h) of this rule states when Medicare payment policies are made using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

   The applicable DWC fee guideline is found in 28 TAC 134.203 (c) which requires the application of Medicare payment policies and DWC conversion factor.

   The payment formula is DWC Conversion factor/Medicare Conversion Factor multiplied by the Medicare Physician Fee Schedule allowable or 59.19/36.0391 x $83.56 = $137.24.

   28 TAC 134.203 (h) states reimbursement shall be the least of the MAR amount or health care provider's usual and customary charge. In this instance the health care's usual and customary charge of $133.39 is the lesser amount. This amount 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 additional payment is due. As a result, the amount ordered is $133.39.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $133.39, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 10, 2020 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.