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 QUITMAN

Respondent Name

TX ASSOC. OF COUNTIES RISK MANAGEMENT POOL

MFDR Tracking Number

M4-20-0001-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

September 3, 2019

Response Submitted By

York

REQUESTOR'S POSITION SUMMARY

"Per our calculations, this bill has been underpaid."

RESPONDENT'S POSITION SUMMARY

"After review, York stood upon original audit results as these codes have a Q4 status and the codes were packaged to the ER visit code of 99281/450."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 7, 2019	Critical Access Hospital Services	$670.71	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and fee guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – REPORTING PURPOSES ONLY

Issues

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

Findings

1. 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). Medicare instead reimburses such services according to special reimbursement provisions that have not been adopted by the Texas Division of Workers' Compensation (DWC) as the basis for payment under any fee guideline.

   DWC's *Hospital Facility Fee Guideline*, 28 Texas Administrative Code (TAC) §134.403(f) determines outpatient reimbursement applying Medicare's OPPS formula and factors. Because the requesting facility is a Critical Access Hospital, reimbursement cannot be determined by applying the formula in 28 TAC §134.403(f). No information to support a contracted fee schedule or negotiated rate was found in the submitted materials. Accordingly, 28 TAC §134.403(e)(3) requires, in the absence of an applicable fee schedule, if payment cannot be determined using the formula in 28 TAC §134.403(f), then payment is determined according to 28 TAC §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 TAC §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 similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published division medical dispute decisions, 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 provide any documentation to discuss, demonstrate or justify that the payment they seek is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The requestor thus failed to meet the requirements of DWC 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 above, 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________	Grayson Richardson	October 4, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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