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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0224-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Critical Access Hospitals are paid by separate rates."

Amount in Dispute: $840.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2019	Emergency Services at Critical Care Hospital	$849.29	$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 of non-network healthcare.
3. No explanation of benefits was submitted be either party in this dispute.

Issues

1. What rule is applicable to services in dispute?

Findings

1. The requestor is seeking reimbursement for emergency room services rendered in a critical care hospital on July 5, 2019.

   The respondent indicated they were to pay the services in dispute but attempts to come to an agreement on the amount with the requestor were unsuccessful.

   The health care provider indicates they are part of a health care network but, this network is not administered by Texas Mutual which is the carrier for the injured worker. This network information will not be considered in this dispute.

   The services in dispute are subject to provisions of 28 TAC §134.1 which states medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with the Division's fee guidelines, a negotiated contract or in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

   Critical Care Access Hospitals do not have a DWC fee guideline. As established, no contract exists. This leaves provisions of 28 TAC 134.1(f) which defines fair and reasonable as reimbursement that is consistent with criteria of Labor Code §413.011, is similar to procedures provided in similar circumstances that receives similar reimbursement and is based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments.

   Review of the submitted documentation found the requestor presented insufficient evidence to support the amount requested met the definition of “fair and reasonable” described above. No additional payment 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

		January 15, 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 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.