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 Co

MFDR Tracking Number
M4-21-1710-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 28, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code. …991 – Underpaid/Denied APC. Not paid per the CAH rates."

Amount in Dispute: $537.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor asserts it was not paid per Critical Access Hospital (CHA) rates. Texas Mutual reviewed the requestor's billing and confirmed the requestor provided outpatient services per type of bill 131 submitted. Per requester's NPI #1[redacted] UT Health Pittsburg, is a General Acute Care Hospital – Critical Access. The requestor did not bill with the correct CAH type of bill, nor submit their CMS Part B per diem rate sheet provide by Medicare for CAH reimbursement. Per TOB 131 OPPS rates were applied."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2021	Critical Care Access Hospital Services	$537.37	$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 guidelines for workers compensation medical claims.
3. The insurance carrier reduced/denied the disputed services with the following reason codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 370 – The hospital outpatient allowance was calculated according to the APC rate, pus a markup
- 610 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS

Issues

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

Findings

1. The requestor is seeking additional reimbursement of services rendered in a Critical Access Hospital. In their reconsideration they reference DWC Rule 134.403 and 134.404.

   These rules apply to acute inpatient hospital care and acute outpatient hospital care. Review of the submitted medical bill finds the rendered services were performed at UT Health Pittsburgh whose NPI indicates a General Acute Care Hospital - Critical Access Hospital. The referenced rules do not apply. Explanation of the applicable rule and fee is discussed below.

2. Under the division's general reimbursement Rule at 28 TAC §134.1(e), payment for health care is calculated by applying a fee from an adopted Division rule or by applying a negotiated contract rate. In the absence of an applicable fee guideline or a negotiated contract, the payment is subject to the division's general fair and reasonable requirements described in 28 TAC 134.1 (f) found below.

   There is no fee guideline for services provided in a Critical Access Hospital. No evidence of a contract was submitted. The DWC general fair and reasonable standard of payment applies to the disputed services.

   The insurance carrier provided evidence of using the CMS OPPS calculation found at www.cms.gov multiplied by 200% to reach the payment amount of $839.63.

   28 TAC 134.1(f) required the health care provider to support their suggested reimbursement is consistent with the criteria of Labor Code §413.011 by providing documentation of similar procedures provided in similar circumstances received similar reimbursement; and their suggested reimbursement is 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.

   Review of the submitted positional statement did not meet the criteria described above. No additional reimbursement 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

		June 23, 2021
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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 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.