TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT Health Quitman

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-21-1888-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 22, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill is not paid per the CAH rates."

Amount in Dispute: $1,293.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above date of service and found that the provider was not due additional money."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 15, 2021	Critical Care Access Hospital Services	$1,293.06	$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:
    - Charge exceeds Fee Schedule allowance (222)
    - Items and/or services are packaged into APC rate. Therefore there is no separate APC payment. (785)
    - This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate (881)

- Reimbursement based on Multiple Imaging Composite APC 8005 for Family 2-CTA without contrast procedure (928)
- 45 – Charge exceeds fee schedule/maximum allowable or contracted fee arrangement
- 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

Issues

1. Is the requestor's position supported?
2. How did the insurance carrier calculate payment?
3. What rule is applicable to reimbursement?
4. Did the requestor support the requirements of fair and reasonable?

Findings

1. The requestor is seeking additional reimbursement of services rendered in a Critical Access Hospital. In their reconsideration they reference CAH rates.

   Review of the submitted medical bill found the type of bill referenced on the CMS 1450, box number four is "131". This is specific to services performed in an Outpatient Hospital Facility not a Critical Access Hospital. The submitted bill does not support the requestors' position statement.

2. 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 $1,044.54.

3. Payment for health care is calculated by applying a fee from an adopted Division rule or by applying a negotiated contract rate. The National Provider Number found on the medical bill is for a Critical Access Hospital. 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 payment is subject to the division's general fair and reasonable requirements described in 28 TAC 134.1 (f) found below.

   DWC Rule 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 that 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.

4. 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

	[redacted]	July 7, 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.