TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
UT Health Quitman

Respondent Name
TX Municipal League Intergovernmental Risk

MFDR Tracking Number
M4-21-2195-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 29, 2021

Requester's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration where they stated, "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $711.31

Respondent's Position

The provider is seeking additional reimbursement on an outpatient hospital bill that was audited correctly accordingly to Medicare guidelines.

Response Submitted by: Flahive, Ogden & Latson

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 15, 2021	Emergency Room	$711.31	$0.00
	Total	$711.31	$0.00

Findings and Decision

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable 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 §134.1 sets out reimbursement guidelines for workers compensation medical claims.

3. The insurance carrier reduced/denied the disputed services with the following reason codes:
    - 370 – The hospital outpatient allowance was calculated according to the APC rate plus a markup
    - 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. Did the requestor support their request for additional reimbursement?

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 Quitman whose NPI indicates a 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.

   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 an explanation of benefits showing use of the APC rate to reach the payment amount of $1,581.24.

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 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 copy of the requestor's reconsideration request did not meet the criteria described above. No additional reimbursement is recommended.

Conclusion

DWC finds the requester has not established that additional reimbursement is due. As a result, the amount ordered is $0.

Order

Under Texas Labor Code §413.031, it is ordered that the requester is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

		September , 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed 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.