TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
UT Health Pittsburg

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-2405-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 24, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 11, 2021	Critical Access Hospital Services	$2,791.31	$0.00
	Total	$2,791.31	$0.00

Requestor's Position

Requestor did not submit a position statement but submit a copy of their reconsideration that states "Underpaid/Denied APC. Bill was not paid per the fee schedule."

Amount in Dispute: $2,791.31

Respondent's Position

Texas Mutual reviewed the requester's billing and confirmed the requestor provided outpatient services per type of bill 131 submitted… Texas Mutual has confirmed that the audit is correct and in accordance with Rule 134.403(f)(1) regarding CMS payment methodology for Outpatient Hospital (OPPS) Fee Guideline.

Response Submitted by: Texas Mutual Insurance

Findings and Decision

Authority

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).

Statutes and Rules

1. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

2. 28 Texas Administrative Code §134.1 sets out reimbursement guidelines for workers compensation medical claims.

3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 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
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 370- This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.

Issues

1. Is insurance carrier's reduction in payment 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 Pittsburg whose NPI ([redacted] indicates a Critical Access Hospital.

   The requestor submitted the medical bill as bill type 131 (Outpatient Hospital) however, the Medicare Claims Processing Manual at www.cms.gov Chapter 4, Section 10.1 states, "*The*

Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except… Critical Access Hospitals (CAHs)."

DWC Rule 28 TAC 134.403 (d) states in pertinent part for coding, billing, reporting and reimbursement of health care Texas workers' compensation system participants shall apply Medicare payment policies. 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.

   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 positional statement did not meet the criteria described above. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		September 22, 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.