

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Rollins Brook Community Hospital

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-22-0727-01

Carrier's Austin Representative

Box Number 45

DWC Date Received

December 13, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 28, 2021	96365	\$365.04	\$0.00
June 28, 2021	96361	\$71.75	\$0.00
June 28, 2021	99285	\$936.59	\$0.00
Total		\$1,373.38	\$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "...documentation does support service being rendered for the compensable injury. Please note coding has been updated."

Amount in Dispute: \$1,373.38

Respondent's Position

Upon notification of this dispute the Office researched the medical billing received from Rollins Brook Community Hospital which determined out of good faith payment will be allowed for service performed on the date of injury...

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 §134.1 sets out reimbursement guidelines for workers compensation medical claims.
2. 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:

- 225 – Penalty or interest payment by payer/only used for plan to plan encounter reporting within the 837
- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking additional reimbursement of services rendered in a Critical Access Hospital.

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

		March 30, 2022
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 electrónico CompConnection@tdi.texas.gov.

