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
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-22-1270-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
February 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 31, 2021	Outpatient Facility Charges	$377.08	$0.00
	Total	$377.08	$0.00

Requestor's Position

"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. This Request for Reconsideration of adjusted and/or disputed amounts is due to 807-Corrected Rebill. CORRECTED BILL PLEASE REVIEW FOR PAYMENT. The table below indicates how the claim should be calculated and the amount due."

Amount in Dispute: $377.08

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for the disputed service. The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the appropriate amount. The primary code 64493 was reimbursed pursuant to the applicable Medicare base rate and Division outpatient modifier. All other codes are inclusive to the primary coded procedure. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response Submitted by: Travelers

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 (TAC) §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 or denied the payment for the disputed services with the following claim adjustment codes:

- 97 – Payment adjusted because 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.
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made…
- 300 – An allowance has been made for a bilateral procedure.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.

Issues

1. 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 Rules 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 indicates a Critical Access Hospital. The referenced rules do not apply. Explanation of the applicable rule and fee is discussed below.

   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.

28 TAC 134.1(f) requires the health care provider to support their 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 electronico CompConnection@tdi.texas.gov.