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
Hill Regional Hospital

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-23-2670-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 10, 2023	73090x	$42.99	$0.00
May 10, 2023	70450	$319.12	$0.00
May 10, 2023	70486	$319.12	$0.00
May 10, 2023	72125	$360.60	$0.00
May 10, 2023	71250	$380.86	$0.00
May 10, 2023	99284	$701.55	$0.00
May 10, 2023	OTHER	$0.00	$0.00
	Total	$2124.24	$0.00

Requestor's Position

"We are requesting an additional payment of $854.02."

Amount in Dispute: $2124.24

Respondent's Position

"This request will be standing on the previous allowance of $1270.22, and no additional allowance is recommended as the charges were paid correctly per the TX Fee Schedule."

Response submitted by: TASB Risk Fund

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) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.01 sets out the medical reimbursement guidelines for fair and reasonable reimbursement.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- 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.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable rule for determining reimbursement for Critical Access Hospital services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards payment for outpatient services provided in a critical access hospital.

   Per Medicare payment policies, critical access hospitals serve rural and low-population areas. Critical access hospitals are not reimbursed using Medicare's Outpatient Prospective Payment System (OPPS). Medicare instead reimburses such services according to provisions that have not been adopted by the Texas Division of Workers' Compensation (DWC) as the basis for reimbursement under any fee guideline.

   DWC's *Hospital Facility Fee Guideline—Inpatient*, Rule §134.403(f) determines reimbursement applying Medicare's OPPS formula and factors. This hospital's National Provider Identifier (NPI) number (field 56 on the bill) identifies the facility as a Critical Access Hospital; as a result, reimbursement cannot be determined by applying the formula in Rule §134.403(f). No information was found to support a contracted fee schedule or negotiated rate. Therefore, in the absence of an applicable fee schedule, Rule §134.403(e)(3) requires payment be determined according to Rule §134.1, regarding a fair and reasonable reimbursement.

2. This dispute regards critical access hospital services with reimbursement subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1. §134.1(e) and (f) states, "(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

   (1) the Division's fee guidelines;
   (2) a negotiated contract; or
   (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

   (f) Fair and reasonable reimbursement shall:

   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be 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."

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004).

Additionally, the Third Court of Appeals held in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach … reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

Texas Labor Code §413.011(d) requires that "Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf."

28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide **"**documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable**."**

Review of the submitted documentation finds that:

- The requestor's position statement states, "We are requesting an additional payment of $854.02."
- The requestor did not submit documentation to support how the requested additional payment would ensure the quality of medical care and achieve effective medical cost control.
- The requestor does not discuss or explain how the requested additional payment would result in similar reimbursement that similar procedures provided in similar circumstances received.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1. The request for additional reimbursement is not supported.

The requestor has failed to meet the requirements of DWC rules and the Labor Code. The requestor has the burden of proof at MFDR to support their request for additional reimbursement by a preponderance of the evidence. DWC concludes the requestor provided insufficient information to meet that burden. Consequently, additional payment cannot be recommended.

<u>Conclusion</u>

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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

______________________	______________________	November 30, 2023
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.