TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
COLLINGSWORTH GENERAL HOSPITAL

Respondent Name
TEXAS ASSOCIATION OF SCHOOL BOARDS RISK MANAGEMENT FUND

MFDR Tracking Number
M4-98-B304-02

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 28, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our dispute is that TASB is saying treatment was not necessary when our only treatment for the patient was pain medication which was medically necessary."

Amount in Dispute: $95.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have no medical records to support the charges billed. . . . Frequent use of emergency room facilities Is not considered efficient utilization of health care."

Response Submitted by: Texas Association of School Boards, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 1998	Emergency Room Care	$95.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §141.1 sets out procedures for requesting a benefit review conference.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 588 – TREATMENT NOT REASONABLE AND NECESSARY, ADJUSTOR'S RECOMMENDATION
   - 587 – PAYMENT AMOUNT WAS PER THE ADJUSTOR'S RECOMMENDATION
   - 524 – ADDITIONAL DOCUMENTATION NEEDED TO PROCESS THIS CLAIM

Issues

1. Are there unresolved issues of medical necessity?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 588 – "TREATMENT NOT REASONABLE AND NECESSARY, ADJUSTOR'S RECOMMENDATION" Review of the submitted information finds that upon reconsideration the insurance carrier did not maintain this denial reason. For that reason the Division concludes that there are no unresolved issues of medical necessity. The disputed fee issues will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute relates to outpatient medical services. These services were not identified in an established fee guideline during the time of treatment; therefore, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 Texas Register 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) until such period that specific fee guidelines are established by the commission."

   Former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states:

   > Guidelines for medical services fees 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. The commission shall consider the increased security of payment afforded by this subtitle.

   Review of the submitted documentation finds that:

   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	September 25, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.