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
Hill Regional Hospital

Respondent Name
American Interstate Insurance Co

MFDR Tracking Number
M4-23-2582-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 9, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 9, 2022	REV 0278 – IMPLANTS	$742.50	0.00
June 9, 2022	REV 0360-CPT 24685	$2690.18	0.00
June 9, 2022	OUTLIER	-2887.99	0.00
June 9, 2022	ALL OTHER		0.00
	Total	$544.69	$0.00

Requestor's Position

"We are requesting an additional payment of $544.69."

Amount in Dispute: $544.69

Respondent's Position

"Upon review, a reconsideration was not properly submitted per the TDI rules for an MDR. Rule 133.250 (b) the health care provider shall submit the request for reconsideration no later than 10 months from DOS."

Response submitted by Amerisafe

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 documentation guidelines for fair and reasonable reimbursement.

Denial Reasons

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

- 01(P12) – The charge for the procedure exceeds the amount indicated in the fee schedule.
- J8(P12) – The allowance for the device intensive procedure was paid at an adjusted rate.
- PN(97) – The service is considered incidental, packaged, or bundled into another service or APC payment.
- P5(P12) – The charge exceeds the APC rate for this service.

Issues

1. What is the DWC reimbursement methodology applicable to this dispute?

2. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking additional payment of services rendered on June 9, 2022. The insurance carrier made a payment based on hospital outpatient allowance according to the APC rate.

   According to CMS NPI Registry at www.npiregistry.cms.hhs.gov. The NPI submitted on the medical bill of 1992285282 is associated with a General Acute Care Hospital – Critical Access.

   The Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, Section 120.1 – Bill Types Subject to OPPS, states in pertinent part, "The following bill types are subject to OPPS:

   > *"All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41 14X and 13X without condition code 41)* ***with the exception*** *of bills from hospitals in Maryland,*

*Indian Health Service, **CAHs**,"*

Based on the above, the additional amount requested by the health care provider is for services rendered in a Critical Access Hospital and not subject to fee guideline of outpatient acute care hospitals.

2. DWC Rule 28 TAC §134.1, requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "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."

   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. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   DWC Rule 28 TAC §133.307 (c)(2)(O) states "Request for MFDR must be legible and filed in the form and manner described by the division. …The request must include: 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."

   The requestor did not submit documentation to support the requested amount of $544.69 as required. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 2024 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.