



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Ward Memorial Hospital

**Respondent Name**

Rural Trust Insurance Co

**MFDR Tracking Number**

M4-24-1114-01

**Carrier's Austin Representative**

Box Number 44

**DWC Date Received**

January 17, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 9, 2023	General Acute Care Critical Access Hospital services	\$25,847.43	\$0.00
<b>Total</b>		\$25,847.43	\$0.00

### Requestor's Position

"Tristar is one of the few Insurance Carrier's that has to have the CAH rates with every bill, even if they already have a copy of it on file. I have already sent them Ward Memorial Hospital's CAH rates on this particular claim, so they should already have it on file. We were told by TDI DWC several months back that a Provider should not have to send the CAH rates or the W-9 form with every bill we submit to the carrier since they are both good for a year."

**Amount in Dispute:** \$25,847.43

### Respondent's Position

The Austin carrier representative for Rural Trust Insurance Co is White Espey PLLC. The representative was notified of this medical fee dispute on January 23, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## **Findings and Decision**

### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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 §134.600](#), details the requirements of prior authorization.

### Denial Reasons

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

- EL(P12) – Per CMS guidelines, Critical Access Hospitals are paid at reasonable costs. Please submit your facility's CAH rates for accurate reimbursement of these charges.
- OP(151) – Based on the code's description, guidelines, anatomical considerations or the nature of service, the maximum number of units of this procedure code has been (illegible) for this date of service.

### Issues

1. Did the requestor support the disputed services received prior authorization?

### Findings

1. The requestor seeks reimbursement for General Acute Care Critical Access Hospital services, rendered on August 9, 2023, at Ward Memorial Hospital. The medical bill indicates a code of 49505 – Repair initial inguinal hernia, age 5 years or older; reducible.

A review of the submitted "Tristar" prior authorization indicates 49650 – Laparoscopy, surgical, repair initial inguinal hernia.

DWC Rule 28 TAC 134.600 (p)(12)(2) Non-emergency health care requiring preauthorization includes

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

Based on our review, the Division found insufficient evidence to support that the services rendered by the requestor were prior authorized as required by rule shown above. No payment 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**

		<u>June 27, 2024</u>
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).