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
Metroplex Adventist Hospital

Respondent Name
Ohio Security Insurance Co

MFDR Tracking Number
M4-24-2769-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
August 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 12, 2024	96372	$130.67	$0.00
April 12, 2024	71101	$203.93	$0.00
April 12, 2024	74176	$184.37	$0.00
April 12, 2024	71250	$46.67	$0.00
April 12, 2024	99284	$20.31	$0.00
	Total	$585.95	$0.00

Requestor's Position

The requestor did not submit a position statement with the request for MFDR but "Per EOB received CPT codes 96372 and 71101 denied payment due to being inclusive. According to CCI edits, codes are separately payable due to modifier 25 added to ER visit. Please review for reconsideration and additional payment as the attached bill was not paid correctly according to the TX workers comp fee schedule."

Amount in Dispute: $585.95

Respondent's Position

"We have again reviewed payment for the services of April 12, 2024, by Metroplex Adventist Hospital and determined that reimbursement was issued according to the guidelines provided by

the Texas Medical Fee Schedule. No additional payment is due."

Response submitted by: Liberty Mutual

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

28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

28 TAC §134.403 sets out the billing and payment for outpatient acute care hospitals.

28 TAC §134.1 sets out the documentation requirements of fair and reasonable.

Denial Reasons

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 4960 – Charge for this procedure exceeds the OPPS Q3 composite adjustment fee schedule allowance.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 56 – Significant, separately identifiable E/M service rendered.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Is the requestor an Acute Care Hospital?
2. What rule is applicable to disputed services?

Findings

1. The requestor is seeking payment for services rendered April 12, 2024. Review of the submitted medical bill found the services were rendered at Metroplex Adventist Hospital in Lampasas, TX. The medical bill indicates the NPI for the facility is 1750392916. Review of the NPPES NPI Registry at https://npiregistry/cms.hhs.gov indicates this facility is a Critical Access Hospital.

   While DWC Rule 134.403 applies to Hospital Facility fee Guideline – Outpatient, section (a)(1) states, "This section applies to medical services provided in an outpatient acute care hospital…".

   As the requestor is not an acute care hospital but rather a critical access hospital, there is no Division fee guideline.

2. DWC 28 TAC §134.203(f) states in pertinent part "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, **or the Division**, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   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.

   The requestor did not submit documentation to support the requested amount of $585.95 as required by 28 TAC §134.1. 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		October 1, 2024
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.