TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
St David's Rehabilitation Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-13-2128-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $29,160.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual believes its payment method to be fair and reasonable because (a) it is derived from nationally recognized published studies, i.e. Medicare's Inpatient Rehab Prospective Payment System; (b) it ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (c) it provides generally for a payment of a fee not 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 action on that individual's behalf."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6 – 16, 2012	Inpatient Rehabilitation Hospital Services	$29,160.15	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 provides for the reimbursement guidelines for care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets for the provisions regarding reimbursement policies and guidelines.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed
   - 18 – Duplicate claim/service
   - CAC - 217- Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 426 – Reimbursed to fair and reasonable

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Did the requestor meet requirements of Rule 133.307?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the disputed services with claim adjustment reason code CAC -217-"Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement."

   28 Texas Administrative Code 134.404 (a) (1) states, "This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008." Review of the submitted medical claim finds facility is "St. Davids Rehabilitation Hospital". This dispute pertains to inpatient rehabilitation services; therefore, the guidelines of 28 Texas Administrative Code §134.404 are not applicable. The carrier's denial code is supported.

   Additional reduction code of 426 – "Reimbursed to fair and reasonable" was used by the carrier. 28 Texas Administrative Code §134.1(f) states,

   > 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) states,

   > 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.

   The carrier's position states, "Texas Mutual's reimbursement was derived from Medicare's payment methodology for inpatient rehab treatment." The carrier has supported their position in how the provisions of Rule 134.1 and Labor Code 413.011 are met.

2. 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) or §134.503 of this title (relating to Pharmacy Fee Guideline) 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 submitted no position statement that asserts that fair and reasonable reimbursement would be 100% of total billed charges.
- The requestor did not support that additional reimbursement of $29,160.15 would be fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the request amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds insufficient evidence to demonstrate or justify that payment sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medial fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parities to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. 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

		November 5, 2015
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 in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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