



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ST. DAVID'S REHAB A SDMC FAC

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-14-1701-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

FEBRUARY 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "EXP REIM \$53,039.00 (The DWC des not have a fee guideline for inpatient rehabilitation, services would be reim at fair/reasonable rate is to accept payment 100% of billed charges \$53,039.00 with CMG CODE / D0703. INSUR PD \$24,079.84. NO PT RESP.. ACCT IS UNDER PD BY \$28,959.16."

Amount in Dispute: \$28,959.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After full review of the dispute packet submitted by the requestor St. David's Rehab A SDMC FAC, the Office will maintain that payment in the amount of \$24,079.84 is correct pursuant to the Divisions rules and payment policies. Pursuant to Medicare's payment policies of utilizing the Rehab PC Pricer for inpatient rehabilitation billing the CMG code of D0703 as included on the UB04 reimburses \$16,839.05 multiplied by 143% equals \$24,079.84."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 7, 2013 Through February 20, 2013	Inpatient Rehabilitation Hospital Services	\$28,959.16	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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, effective March 1, 2008, provides for the reimbursement guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45-Charges exceed your contracted/legislated fee arrangement.
 - 217-Based on payer reasonable and customary fees. No maximum allowable defined by Legislated fee arrangement. (Note: To be used for property and casualty only).
 - 97-The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.
 - W3-Additional payment made on appeal/reconsideration.
 - No indication from provider for separate reimbursement for implants; DRG-945 paid @ 143%. Emerg inpat services/rehab.
 - 18-Exact duplicate claim/service.
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

Findings

1. The insurance carrier reduced or denied disputed services with reason code “45-Charges Exceed Your Contracted/Legislated Fee Arrangement.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(a) states “Applicability of this section is as follows. (1)This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.”

28 Texas Administrative Code §134.404(b)(1) states “‘Acute care hospital’ means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.”

The requestor provided inpatient rehabilitation services; therefore, the guidelines of 28 Texas Administrative Code §134.404 are not applicable.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which 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.”
4. 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.
5. 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’s position statement asserts that “The DWC des not have a fee guideline for inpatient rehabilitation, services would be reim at fair/reasonable rate is to accept payment 100% of billed charges.”
 - The requestor does not discuss or explain how 100% of billed charges supports the requestor’s position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that 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 failed to establish 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 services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

01/29/2015
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, effective May 31, 2012, 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 MDR 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.