



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

NIX HEALTH CARE SYSTEM

**Respondent Name**

HARTFORD UNDERWRITERS INSURANCE

**MFDR Tracking Number**

M4-16-0495-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

OCTOBER 26, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The amount paid by the Carrier, The Hartford, in this case does not comply with the Inpatient Hospital Facility Fee Guidelines outlined in Rule §134.404."

**Amount in Dispute:** \$13,438.68

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Based on the information and documentation we feel this bill was paid appropriately, per the fee schedule and with the reconsideration adjustment."

**Respondent's Supplemental Position Summary:** "Per the Medicare PC Pricer using Provider's Medicare # 450130, CMG # C0902, date range 10/17-10/26 (10 days total) reimbursement should be \$14,450.19."

**Response Submitted by:** The Hartford

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2014 through October 26, 2014	Inpatient Rehabilitation Hospital Services	\$13,438.68	\$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**

- 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404, effective March 1, 2008, provides for the reimbursement guideline for acute care inpatient hospital services.
- 28 Texas Administrative Code §134.1, effective March 1, 2008, sets forth general provisions related to medical reimbursement.
- Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

- 169-Reimbursement based on ratio, percentage or formula set by state guidelines.
- P12-Workers compensation jurisdictional fee schedule adjustment.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review it was determined that his claim was processed properly.
- 1115-We find the original review to be accurate and are unable to recommend any additional allowance.

## Issues

1. Does a timely filing issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement?

## Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are October 17, 2014 through October 26, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 26, 2015. Review of the submitted documentation finds that the disputed services rendered on October 17, 2014 through October 25, 2014 do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section for these dates; consequently, the requestor has waived the right to medical fee dispute resolution for services rendered on October 17, 2014 through October 25, 2014.

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, 28 Texas Administrative Code §134.404 is 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 did not support position that additional reimbursement of \$13,438.68 would be a fair and reasonable rate of reimbursement for the services in this dispute.
  - 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**

The Division would like to emphasize that individual medical 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 parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position 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

11/24/2015  
\_\_\_\_\_  
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.**