



# 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

NORTH TEXAS REHABILITATION CENTER

Respondent Name

ACCIDENT FUND NATIONAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-1545-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

November 16, 2018

#### REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "this is not an agreed amount and we would like our bills to be considered for additional payment.... The services we are providing, a Brain Injury Program has not yet been established and according to the TDI Guidelines, ... if a fee schedule is not yet established ... you have to come, to a Fair and Reasonable rate. We have attached the EOB's from Gallagher Bassett along with 10 other insurance companies showing that our bills are paid between 80 and 100% of billed charges. ... Carriers payments are not explained, notice their payments and different amounts are paid depending who adjudicated the claim."

Amount in Dispute: \$67,911.34

#### RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier's is working with its audit company to determine how the reductions in the billing were applied, but as of the date of this letter has not been provided sufficient information to determine the appropriate reductions."

Response Submitted by: Stone Loughlin Swanson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 14, 2018 to April 24, 2018	Professional Medical Services	\$67,911.34	\$67,911.34

#### 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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Insurance Code 1305.005 sets out requirements regarding notice to injured employees.
5. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
  - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
  - 877 – REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.
  - 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 THIS CLAIM WAS PROCESSED PROPERLY.
  - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
  - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
  - 10 – THE BILLED PROCEDURE REQUIRES THE USE OF A MODIFIER CODE
  - 5165 – BASED ON THE RECEIPT OF ADDITIONAL INFORMATION AND/OR CLARIFICATION, WE ARE RECOMMENDING FURTHER PAYMENT BE MADE FOR THE ABOVE NOTED PROCEDURE CODE(S).

### **Issues**

1. Is there a contracted rate or fee arrangement applicable to the services in dispute?
2. Did the requestor support that the payment sought is a fair and reasonable reimbursement for the services?
3. Did the respondent support that the insurance carrier's payment was fair and reasonable?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed services with claim adjustment reason codes:

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
- 877 – REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.

Additionally, EOBs contain the remittance comment: "NETWORK REDUCTION: COVENTRY P&T THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR HCN CONTRACT WITH FIRST HEALTH."

However, the requestor's position statement asserts "this is not an agreed amount ..."

Based on information maintained by the division, the insurance carrier has not previously reported to the division that this injured employee's claim is subject to a workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305.

Insurance Code §1305.005(d)(1) requires employers to "obtain a signed acknowledgment from each employee . . . that the employee has received information concerning the network and the network's requirements."

Per Insurance Code §1305.005(h), "An insurance carrier that establishes or contracts with a network is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section."

Review of submitted information finds no acknowledgment of signed notice or other documentation to support the injured employee's claim is subject to the requirements of a workers' compensation HCN under Chapter 1305. Consequently, the disputed services must be reviewed according to the requirements of Title 5, Labor Code.

The respondent did not present any evidence to support a contract between the insurance carrier and the provider or between the provider and a workers' compensation HCN to which the carrier had access.

No evidence was presented to support a contracted amount or fee arrangement applicable to the disputed services. The division therefore finds the insurance carrier's payment reduction reasons are not supported. Reimbursement for the services will be considered in accordance with division rules and medical fee guidelines.

2. This dispute regards multidisciplinary brain injury rehabilitation services for which the division has not established a medical fee guideline. No documentation was found to support a negotiated or contracted rate. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

In the following analysis, the evidence presented by both parties to support their positions as to the fair and reasonable payment amount is examined in order to determine which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the services in dispute.

The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

28 Texas Administrative Code §134.1(f) requires 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.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 South Western Reporter Third 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 South Western Reporter Third 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

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. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

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 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

The division will first review the information presented by the requestor to determine whether the burden is met to show the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services. If the requestor's evidence is persuasive, the division will then review the evidence presented by the respondent to support that the amount paid was a fair and reasonable reimbursement for the disputed services.

Review of the submitted documentation finds that:

- The requestor seeks payment of their full billed charges of \$2800 per day of treatment.
- The division previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 Texas Register 6271).
- In formulating the fee guidelines, the division further considered alternative methods of reimbursement that use hospital charges as their basis. Such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 Texas Register 6268-6269).

- While outpatient brain injury rehabilitation services are not the same as hospital care, the above principle is of similar concern here. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services.
- Payment of the provider's billed charge is thus not acceptable when it leaves the payment amount in the health care provider's control — which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living.
- Accordingly, the use of a health care provider's "usual and customary" charges cannot be favorably considered unless other data or documentation is presented to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In this dispute, however, the requestor has submitted additional information to support that \$2800.00 per day of treatment is a fair and reasonable reimbursement amount.
- The requestor submitted redacted copies of eight EOBs from different insurance carriers showing payment for the same or similar services of the full requested amount of \$2,800.00.
- The submitted evidence supports that a number of diverse payers found this amount to be an acceptable payment for the services in dispute.
- The documentation supports that the proposed payment achieves effective medical cost control while still ensuring the quality of medical care.
- It shows that similar procedures provided in similar circumstances have received similar reimbursement.
- The division finds the requested amount to be consistent with the criteria of Labor Code §413.011.
- The division concludes the requestor has satisfied the requirements of Rule §134.1.

The request for additional reimbursement is supported. The division concludes the requestor has discussed, demonstrated, and justified that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute.

3. Because the requestor has met the burden to show the amount sought is a fair and reasonable amount, the division now reviews the information presented by the respondent to support whether the amount paid was a fair and reasonable reimbursement for the services in dispute.

Rule §133.307(d)(2)(E)(v) requires the insurance carrier's response to include:

documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 ... if the dispute involves health care for which the division has not established a MAR or reimbursement rate

Review of the submitted documentation finds that:

- Rule §134.1(g) requires the insurance carrier to consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts.
- Review of the submitted EOBs finds the carrier's payment amounts for the services to be inconsistent.
- The EOBs do not describe how the payment was calculated nor account for the difference in the payments.
- The respondent did not present information to describe the methodology they have adopted to determine the payment amounts; nor did they explain how the adopted methodology is fair and reasonable or show that the methodology is consistently applied.
- The respondent presented no documentation to discuss, demonstrate, or justify that the amount paid was a fair and reasonable reimbursement in accordance with the criteria of Labor Code §413.011.
- The respondent did not support that the amount paid satisfies the requirements of Rule §134.1.
- The division finds the respondent has failed to support that the insurance carrier paid a fair and reasonable reimbursement for the services in dispute.

The respondent's position is not supported. The respondent failed to demonstrate or justify that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The division concludes the respondent has not met the requirements of 28 Texas Administrative Code §133.307(d)(2)(E)(v).

4. The division concludes the requestor has supported their request for additional reimbursement, whereas the respondent failed to support that they reimbursed the services at a fair and reasonable rate. Accordingly, reimbursement for the disputed services is calculated as follows:

- The recommended reimbursement for the 32 disputed visits at \$2,800.00 per visit is \$89,600.00.

The requestor has established that the fair and reasonable reimbursement for the disputed services is \$89,600.00. The insurance carrier paid \$21,403.66. The requestor seeks payment of \$67,911.34. This amount is recommended.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$67,911.34.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$67,911.34, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	<u>Grayson Richardson</u>	<u>February 1, 2019</u>
Signature	Medical Fee Dispute Resolution Officer	Date
_____	<u>Martha Luévano</u>	<u>February 1, 2019</u>
Signature	Director of Medical Fee Dispute Resolution	Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form DWCO45M) in accordance with the form’s instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.