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
GREAT AMERICAN ALLIANCE INSURANCE COMPANY

MFDR Tracking Number
M4-19-3844-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 19, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"this is not an agreed amount … The services we are providing, a Brain Injury Program has not yet been established and according to the TDI Guidelines, … Carriers payments are not explained, notice their payments and different amounts are paid depending who adjudicated the claim."

RESPONDENT'S POSITION SUMMARY

"The provider was reimbursed at specific rates based upon whether the services were cognitive rehabilitation, therapeutic exercises, bio feedback, group therapy, individual counseling or speech therapy. The reimbursement rates were respectively, $141.16 per hour, $90.00 per hour, $160.22 per hour, $42.44 per hour, $211.76 per hour and $125.71 per hour.

The carrier's position is that those reimbursement rates were correct and were reflective of the actual services provided on each specific date, whereas the provider's request for reimbursement of $2,800 per day was not based upon the specific services that were provided on that date.

The carrier's reimbursement rate is more than fair and reasonable. The provider billed under CPT code 97799. That is a CPT code that addresses rehabilitation programs such as work conditioning, work hardening, outpatient rehabilitation and chronic pain management programs. The reimbursement rate based upon the maximum allowable reimbursement is $36.00 per hour, $64.00 per hour, $90.00 per hour and $125.00 per hour, respectively. Those reimbursement rates are considerably lower than the reimbursement rates that the carrier used in its EOBs. … the carrier could have used the rehabilitation programs as instructive in determining what was fair and reasonable. However, the carrier used higher rates in reaching what it believes to be a fair and reasonable reimbursement rate."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 7, 2018 to September 7, 2018	Traumatic Brain Injury Rehabilitation	$66,783.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.1 sets out general provisions regarding medical reimbursement.
3. The insurance carrier reduced payment for the disputed services with the following reason codes:
   - 131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
   - 144 – INCENTIVE ADJUSTMENT, E.G. PREFERRED PRODUCT/SERVICE.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 375 – PLEASE SEE SPECIAL *NOTE* BELOW
     - UPHOLD. NO ADDITIONAL DOCUMENTATION HAS BEEN SUBMITTED TO SUPPORT AN ADDITIONAL ALLOWANCE.
   - 375 – PAID $720.00 PER AGREEMENT.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL
   - 465 – ONLY THE PROFESSIONAL PORTION IS REIMBURSED THE HPSA/PSA BONUS.
   - 751 – EXTENT OF INJURY NOT FINALLY ADJUDICATED.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
   - 95 – PLAN PROCEDURES NOT FOLLOWED
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - PDC – THIS BILL WAS ADJUDICATED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824
   - U03 – THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
4. The insurance carrier's explanations of benefits (EOBs) also contained this additional remittance advice:

   Billed charges are for a brain injury program approved under non-specific code 97799. Texas currently has 4 program that are identified within the guidelines where this code is used. One of those programs is an Outpatient Medical Rehabilitation Program where Modifier Code MR is used and the rate for this program for a CARF accredited facility is $90/hr. The head injury program being billed by this provider includes therapy/rehab hours that are reasonably the same as would be involved in this type of program.
   For the hours for rehab/therapy the Carrier … is using this same hourly rate for this CARF accredited facility. For the more specific services that would not necessarily be included in such a program, and are more specific to this brain injury program the Carrier in an effort to find a Fair & Reasonable rate for these services has chosen to break these down by type of service performed as follows:

   Therapeutic Exercise: 97799 Carf Rehab Program x $90.00 per hour
   Cognitive Rehab: G0515-$141.16 per hour
   Biofeedback: 90902 $160.22 per hour
   Group Therapy: 90853 $42.44 per hour
   Speech Therapy: 92507 $125.71 per hour

Issues

1. Are the disputed services subject to a contracted fee agreement or claim specific negotiated discount?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier reduced payment for disputed services with claim adjustment reason codes:
   - 131 - CLAIM SPECIFIC NEGOTIATED DISCOUNT.
   - 375 – PAID $720.00 PER AGREEMENT.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - PDC – THIS BILL WAS ADJUDICATED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824

   No information was presented to support the disputed services are subject to a claim specific negotiated discount, contracted rate or any contractual fee agreement between the parties to this dispute. The above payment reduction reasons are not supported. The disputed services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. This dispute involves reimbursement for services provided as part of an interdisciplinary traumatic brain injury rehabilitation program for which the division has not established a medical fee guideline.

   Review of the submitted information finds no documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network. 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).

   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.

   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.

   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."

   In the following analysis, the submitted information is examined to determine which party presents the best evidence to support a payment that achieves 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.

3. The division first considers whether the requestor has met the burden to support that the payment amount requested is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, the division will then review the evidence presented by the respondent.

   Rule §133.307(c)(2)(O) requires the health care provider's request to include:

   > 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

Review of the submitted information finds:

- The requestor asks for reimbursement of $2,800.00 per day of treatment.
- The division has 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 and rejected alternative payment methods that used hospital charges as their basis because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269).
- While traumatic brain injury rehabilitation services are not the same as hospital care, the above principle is of similar concern in this dispute. 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 would leave the determination of the payment amount in the health care provider's own hands — 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.
- Thus, 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 the payment amount sought is fair and reasonable.
- The requestor provided a copy of a previous Medical Fee Dispute Resolution decision in which the division had found a fee of $2,800 per day to be fair and reasonable for the brain injury rehabilitation services rendered to the injured employee in that dispute.
- However, the requestor did not discuss whether the services involved in the previous dispute were the same or substantially similar to the services in this dispute.
- The requestor's position statement asserts that in the absence of an established or negotiated fee schedule, "you have to come, to a Fair and Reasonable rate."
- However, the position statement does not explain how the requested payment would result in a fair and reasonable rate for the services provided.
- The requestor did not discuss how the proposed payment would ensure the quality of medical care.
- The requestor did not discuss how the proposed payment achieves effective medical cost control.
- The requestor did not discuss how the proposed payment ensures that similar services would receive similar reimbursement.
- The requestor did not show that the amount sought is consistent with the criteria of Labor Code §413.011
- The division concludes the requestor has not satisfied the requirements of Rule §134.1.

Upon review of the position statement and supporting information in the health care provider's request, the division concludes the requestor failed to meet the burden to support by a preponderance of the evidence that additional payment is due. Nor did the requestor sufficiently discuss, demonstrate or justify that the payment sought would result in a fair and reasonable reimbursement for the services in dispute. Consequently, additional reimbursement cannot be 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional payment is due.
As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 14, 2019
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	June 14, 2019
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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.