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
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4091-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 10, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"[the injured employee] was approved by utilization review for an 'Interdisciplinary Traumatic Brain Injury Program' … A fee schedule has not yet been determined for this type of treatment. (THIS SERVICE IS NOT CHRONIC PAIN MANAGEMENT OR OUTPATIENT MEDICAL REHABILITATION)…. this is not an agreed amount and we would like our bills to be considered for additional payment…. In addition, we recently took a similar claim for a Brain Injury Patient to MDR and received a decision in our favor. Decision attached…. 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."

RESPONDENT'S POSITION SUMMARY

"Texas Mutual Insurance (TMI) based its payment on the MAR for Outpatient Medical Rehabilitation Programs, $90.00 per hour…. Outpatient Medical Rehabilitation Programs are similar to, in many respects, outpatient brain injury programs…. The agency, by establishing a MAR for Outpatient Medical Rehabilitation Programs, has already determined $90.00 per hour is fair and reasonable… TMI's payments to the requester were consistent…. Other brain injury outpatient rehab programs are paid by TMI in the same manner… TMI believes the amounts paid to the requester meets the requirements of Rule 134.1…. No additional payment is due."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 8, 2018 to July 19, 2018	Brain Injury Rehabilitation Program	$29,055.50	$25,610.00

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. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines

4. The insurance carrier reduced/denied payment for the disputed services with the following reason codes:
    - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
    - 18 – EXACT DUPLICATE CLAIM/SERVICE
    - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
    - 138 – APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET
    - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
    - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - 426 – REIMBURSED TO FAIR AND REASONABLE.
    - 723 – SUPPLEMENTAL REIMBURSEMENT ALLOWED AFTER A RECONSIDERATION OF SERVICES FOR INFORMATION CALL 1-800-937-6824.
    - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
    - 725 – APPROVED NON-NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C).
    - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED.
    - 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION.
    - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
    - 879 – RULE 133.250(B) - HEALTH CARE PROVIDER SHALL SUBMIT THE REQUEST FOR RECONSIDERATION NO LATER THAN 10 MONTHS FROM THE DATE OF SERVICE
    - D25 – APPROVED NON-NETWORK PROVIDER FOR WORKWELL, TX NETWORK CLAIMANT PER RULE 1305.153(C).
    - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
    - P5 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT.
    - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Are the disputed services subject to a contracted fee arrangement?
3. What is the applicable rule for determining reimbursement of the disputed services?
4. Did the requestor support the request for additional payment?
5. Did the respondent support the amount paid was a fair and reasonable payment?
6. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to medical fee dispute resolution (MFDR).

   Rule §133.307(c)(1)(B) provides for certain exceptions to the timely filing deadline.

   Rule §133.307(c)(1)(A) requires a request for MFDR that does not involve issues identified in subparagraph (B) to be filed no later than one year after the date(s) of service in dispute.

   The dates of service in dispute begin on May 8, 2018. The request for medical fee dispute resolution was received on Friday, May 10, 2019. This receipt date is later than one year after disputed dates of service May 8, 2018 and May 9, 2018. Review of the submitted information finds no issues related to the exceptions provided in Rule §133.307(c)(1)(B) to the timely filing limit. Accordingly, the division concludes the requestor has waived the right to MFDR for disputed dates of service May 8 and May 9, 2018.

   The request for MFDR of dates of service May 15, 2018 through July 19, 2018 was timely received by the division; accordingly, these services are eligible for review.

2. The insurance carrier reduced payment for disputed services with claim adjustment reason codes:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.

   No information was presented to support the disputed services are subject to contracted fee arrangement between the parties to this dispute. The above payment reduction reason is not supported. The disputed services will therefore be reviewed for reimbursement in accordance with division rules.

3. 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.

4. 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.
- In this case, however, the requestor has presented evidence to support that the payment amount sought would be a fair and reasonable rate of reimbursement for the services in dispute.
- 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.
- The requestor thus shows the requested reimbursement is based on published division medical dispute decisions in accordance with the requirement of Rule §134.1(f)(3).
- Additionally, the requestor provided redacted copies of EOBs from eight different insurance carriers showing payment of $2,800 per day for similar services.
- The submitted evidence supports that several diverse insurance carriers found $2,800.00 to be an acceptable payment for services that were the same or similar to the services in dispute.
- The submitted documentation supports 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 receive 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.

5. Because the requestor has met the burden to show the amount sought is a fair and reasonable reimbursement, 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.
   - The carrier asserts that "TMI's payments to the requestor were consistent."
   - Review of the submitted EOBs finds however that the carrier's payments were not consistent.
   - The EOBs do not explain how the payments were calculated nor account for the difference in the payments.
   - The respondent states "Texas Mutual Insurance (TMI) based its payment on the MAR for Outpatient Medical Rehabilitation Programs, $90.00 per hour…. Outpatient Medical Rehabilitation Programs are similar to, in many respects, outpatient brain injury programs"

- The respondent did not present documentation to support its position that outpatient medical rehabilitation programs are similar to outpatient brain injury programs.
- The response states "Other brain injury outpatient rehab programs are paid by TMI in the same manner…"
- However, the respondent did not present any redacted EOBs or other documentation to support that TMI reimburses other brain injury outpatient rehab programs in the same manner.
- The response states, "TMI believes the amounts paid to the requester meets the requirements of Rule 134.1."
- However, the response did not explain how the amount paid satisfies the requirements of Rule §134.1.
- The response failed to support the amount paid was a fair and reasonable reimbursement in accordance with the criteria of Labor Code §413.011.
- The respondent failed to support that the insurance carrier's payments were fair and reasonable.

The respondent's position is not supported. The carrier did not meet the requirements of Rule §133.307(d)(2)(E)(v). The submitted documentation did not sufficiently discuss, demonstrate, or justify that the amounts paid by the carrier were a fair and reasonable reimbursement in accordance with Labor Code §413.011 and Rule §134.1. The respondent failed to show by a preponderance of the evidence that the amount paid was a fair and reasonable reimbursement for the services in dispute.

6. The division finds the requestor has supported by a preponderance of the evidence that the reimbursement method requested of $2,800 per day (or $350 per hour) would provide a fair and reasonable payment for the services in dispute. Conversely, the respondent's position was not persuasive. The carrier failed to sufficiently support that the amounts it paid were fair and reasonable.

   Reimbursement is therefore calculated as follows:

Service Date	Hours	Base Rate	Total	Paid	Due	Disputed	Order
May 8, 2018	Service date not eligible for dispute resolution						$0.00
May 9, 2018	Service date not eligible for dispute resolution						$0.00
May 15, 2018	6.50	$350	$2,275.00	$585.00	$1,690.00	$1,690.00	$1,690.00
May 16, 2018	8.00	$350	$2,800.00	$720.00	$2,080.00	$2,080.00	$2,080.00
May 18, 2018	8.00	$350	$2,800.00	$720.00	$2,080.00	$2,080.00	$2,080.00
May 21, 2018	6.50	$350	$2,275.00	$585.00	$1,690.00	$1,690.00	$1,690.00
May 22, 2018	6.25	$350	$2,187.50	$562.50	$1,625.00	$1,625.00	$1,625.00
May 24, 2018	6.75	$350	$2,362.50	$607.50	$1,755.00	$1,755.00	$1,755.00
May 30, 2018	5.25	$350	$1,837.50	$472.50	$1,365.00	$1,365.00	$1,365.00
May 31, 2018	6.75	$350	$2,362.50	$607.50	$1,755.00	$1,755.00	$1,755.00
June 6, 2018	6.25	$350	$2,187.50	$562.50	$1,625.00	$1,625.00	$1,625.00
June 12, 2018	6.00	$350	$2,100.00	$540.00	$1,560.00	$1,560.00	$1,560.00
June 13, 2018	6.25	$350	$2,187.50	$562.50	$1,625.00	$1,625.00	$1,625.00
June 21, 2018	6.25	$350	$2,187.50	$562.50	$1,625.00	$1,625.00	$1,625.00
June 26, 2018	6.50	$350	$2,275.00	$585.00	$1,690.00	$1,690.00	$1,690.00
June 27, 2018	6.25	$350	$2,187.50	$562.50	$1,625.00	$1,625.00	$1,625.00
July 19, 2018	7.00	$350	$2,450.00	$630.00	$1,820.00	$1,820.00	$1,820.00

Total Due: $25,610.00

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.

The applicable rule for determining reimbursement of the disputed services is 28 Texas Administrative Code §134.1, regarding a fair and reasonable reimbursement.

For the reasons stated above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $25,610.00.

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 $25,610.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

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.