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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT Health East Texas Rehabilitation

Respondent Name
Texas Association of Counties Rmp

MFDR Tracking Number
M4-20-0703-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This inpatient rehabilitation bill has been underpaid."

Amount in Dispute: $12,895.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the Medical Dispute Resolution, Careworks stands on the original audit results."

Response Submitted by: CareWorks

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2019 – June 7, 2019	Inpatient rehabilitation services	$12,895.68	$0.00

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 §134.1 sets out reimbursement guidelines for workers compensation medical claims.
3. Neither party submitted an explanation of benefits for this medical bill.

Issues

1. Is the requestor's position supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking additional reimbursement of inpatient rehabilitation services rendered in May and June of 2019. In their reconsideration their reference DWC Rule 134.403 and 134.404. These rules apply to acute inpatient hospital care and acute outpatient hospital care. Review of the submitted medical bill finds the rendered services were performed at UT Health East Texas Rehabilitation Hospital. The referenced rules do not apply. Explanation of the applicable rule and fee is discussed below.

2. Under the division's general reimbursement Rule at 28 TAC §134.1(e), payment for health care is calculated by applying a fee from an adopted Division rule or by applying a negotiated contract rate. In the absence of an applicable fee guideline or a negotiated contract, the payment is subject to the division's general fair and reasonable requirements described in 28 TAC 134.1 (f) found below.

   There is no fee guideline for services provided at an inpatient rehabilitation facility. Unless there is a contract, the DWC general fair and reasonable standard of payment applies to the services of an inpatient rehabilitation facility.

   No evidence of a written contract was found. The documentation supports that the health care provider and the carrier mutually agreed (health care provider submitted a corrected claim based on insurance carrier's instruction) that payment for CMG Code C0502 of Medicare's Inpatient Rehabilitation Hospital represented a fair and reasonable amount of payment.

   The insurance carrier provided evidence of using the CMS IRP Prospective Payment calculation found at www.cms.gov multiplied by 143% to reach the payment amount of $18,825.79.

   The health care provider filed this medical fee dispute because it disagrees with the carrier's calculation of the fee using the mutually-agreed upon methodology. Specifically, the parties disagree over which Medicare inpatient rehabilitation prospective payment amount should be used in the calculation.

   28 TAC 134.1(f) required the health care provider to support their suggested reimbursement is consistent with the criteria of Labor Code §413.011, that similar procedures provided in similar circumstances received similar reimbursement; and their suggested reimbursement 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.

   Review of the submitted "allowed explanation" was not sufficient to meet the criteria described above.

   No additional reimbursement is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 10, 2020
Signature	Medical Fee Dispute Resolution Officer	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, 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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.