TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Covenant Specialty Hospital

Respondent Name
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-21-1930-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
June 29, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 15, 2020 through September 7, 2020	Long Term Care Hospital Services	$229,075.72	$0.00
	Total	$229,075.72	$0.00

Requestor's Position

This is an inpatient bill that should pay per TDI Rule 134.404.....This Facility falls under the Long-Term Care PC Pricer.

Amount in Dispute: $229,075.72

Respondent's Position

We base our payment on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim. The bill has been reviewed and adjusted for payment – copies of EOBS are submitted for your review.

Response Submitted by: Liberty Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §134.1 sets out the procedures for reimbursement guidelines for workers' compensation medical claims.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 4896 – Payment made per Medicare's IPPS methodology. With the applicable state markup
- 309 – The charge for this procedure exceeds the fee schedule allowance
- W3 – Additional payment made on appeal/reconsideration additional payment made on appeal/reconsideration

Issues

1. Is the requestor's position supported?

2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking additional reimbursement of services rendered in a Long Term Care Hospital. In their position statement they reference DWC Rule 134.404.

   This rule applies to acute inpatient hospital care. Review of the submitted medical bill finds the rendered services were performed at Covenant Specialty Hospital whose NPI ([redacted] indicates a Long Term Care Hospital. The referenced rule does not apply. Explanation of the applicable rule and fee is discussed below.

   Under the division's general reimbursement Rule at 28 TAC §134.1(e), payment for health care is calculated by applying the Division's fee guidelines if applicable, 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).

   There is no DWC fee guideline for services provided in a Long Term Care Hospital. No evidence of a negotiated contract was submitted. The DWC general fair and reasonable standard of payment applies to the disputed services.

DWC Rule 28 TAC 134.1(f) states that fair and reasonable reimbursement shall

- Be consistent with the criteria of Labor Code §413.011
- Ensure that similar procedures provided in similar circumstances receive similar reimbursement
- Be based on nationally recognized published studies, published Division medical dispute decision, and/or values assigned for services involving similar work and resource commitments, if available

Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that the payment amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. The insurance carrier made an additional payment of $149,385.31 on July 16, 2021 for a total payment of $185,326.54 the requestor did not choose to withdraw, additional payment cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		September 8, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

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A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC

must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.