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

Requester Name
UT East Texas Rehab

Respondent Name
Travelers

MFDR Tracking Number
M4-21-2214-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 30, 2021

Requester's Position

No position statement was found within submitted documentation.

Amount in Dispute: $11,707.96

Respondent's Position

The Provider contends they are entitled to additional reimbursement for the disputed services. Although the Provider submits a dollar figure for additional reimbursement, they do not submit a position statement, as required by Rule 133.307(c)(2)(N), so there is no identifiable bases for how the Provider arrived at this figure.

Response Submitted by: Travelers

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 12, 2021	Inpatient Rehabilitation	$11,707.96	$0.00
	Total	$11,707.96	$0.00

Findings and Decision

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).

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. The insurance carrier reduced the disputed services with the following reason codes:
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
   - 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking additional reimbursement of services rendered in a Rehabilitation Hospital.

   There is no fee guideline for services provided in a Rehabilitation Hospital. No evidence of a contract was submitted. The DWC general fair and reasonable standard of payment applies and 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.

   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 by providing documentation of similar procedures provided in similar circumstances received similar reimbursement; and their suggested reimbursement is 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 documentation found insufficient evidence to support the criteria described above. No additional reimbursement is recommended.

Conclusion

DWC finds the requester has not established that additional reimbursement is due. As a result, the amount ordered is $0.

Order

Under Texas Labor Code §413.031, it is ordered that the requester is entitled to $0 additional reimbursement for the disputed services.

Authorized Signature

		August 25, 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**.

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 512-804-4812.