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
UT Health East Texas Rehab

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-22-0549-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
November 17, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 5, 2021	OCC Therapy	$242.02	$0.00
	Total	$242.02	$0.00

Requestor's Position

The requestor did not submit a position statement but submit a copy of their reconsideration that states, "Underpaid/Denied therapy. Not paid per CAH Rates."

Amount in Dispute: $242.02

Respondent's Position

Our Fee Schedule team has determined that the provider is not due an additional allowance...

Response Submitted by: Gallagher Bassett

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 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:

- 119 – Benefit maximum for this time period or occurrence has been reached
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking additional reimbursement of services rendered in a Rehabilitation Hospital. In their reconsideration they 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 East Texas Rehabilitation whose NPI (1174021695) indicates a 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 in a Rehabilitation Hospital. No evidence of a contract was submitted. The DWC general fair and reasonable standard of payment applies to the disputed services.

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 reconsideration did not meet the criteria described above. No additional reimbursement is 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

		January 12, 2022
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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.