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
NORTHEAST METHODIST HOSPTIAL

Respondent Name
STANDARD FIRE INSURANCE CO.

MFDR Tracking Number
M4-23-0073-01

Austin Carrier Representative
Box Number 5

DWC Date Received
September 7, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 7, 2021 through September 14, 2021	Inpatient Services	$19,685.88	$0.00
	Total	$19,685.88	$0.00

Requestor's Position

"As services occurred at a certified Rehabilitation Facility, for which Medicare IPPS has not established a reimbursement rate, payment at the above-referenced formula Is not applicable... Hospital is expecting payment on a reasonable cost basis. Hospital is confident that the facility's charges are reasonable; therefore, we expect the allowable to be our billed charges."

Amount in Dispute: $19,685.88

Respondent's Position

"The Provider contends they are entitled to reimbursement at full billed charge. The Division has consistently rejected the argument that full or a percentage of billed charges is consistent with the reimbursement criteria set forth in Texas Labor Code Sect. 413.011(d). . . This cherry-picked selection of EOBs does not reflect dates of service and does not even support the Provider's contention that the carriers are paying full billed as one has a 30% discount. This reflects that the Provider themselves acknowledges that less than their billed charge is fair and reasonable reimbursement. . . Consequently, the Carrier has utilized similar procedures with similar circumstances to apply a nationally recognized reimbursement standard with appropriate modifications as required by Rule 134.1(f)."

Response Submitted by: Travelers

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.1 sets out general provisions regarding medical reimbursement.
4. Texas Insurance Code 1305.005 sets out requirements regarding notice to injured employees.
5. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.

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

- P12 – WORKERS COMPENSASTION JURISDICTIONAL FEE SCHEDULE.
- 4896 – PAYMENT MADE PER MEDICARE'S IPPS METHODOLOGY, WITH THE APPLICABLE STATE MARKUP.
- W3 – BILL IS A RECONSIDERATION OR APPEAL.

Issues
1. Is there a contracted rate or fee arrangement applicable to the services in dispute?
2. Did the requestor support that the payment sought is a fair and reasonable reimbursement for the services?
3. Is the requestor entitled to additional reimbursement?

Findings
1. This dispute regards inpatient rehabilitation services for which the division has not established a medical fee guideline. No documentation was found to support a negotiated or contracted rate. Payment is therefore subject to the general medical reimbursement provisions of 28 TAC §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).

   To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   • TLC §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. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

• 28 TAC §134.1(e)(3) states, "Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."

• 28 TAC §134.1(f) states, "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."

• 28 TAC §134.230 states, "The following shall be applied to Return to Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier."

• 28 TAC §134.230 states, "(1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).

• 28 TAC §133.307(c)(2)(O) requires the requestor to provide "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 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

In the following analysis, the evidence presented by both parties to support their positions as to the fair and reasonable payment amount is examined in order to determine which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the services in dispute.

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."

2. The division will first review the information presented by the requestor to determine whether the burden is met to show the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services. If the requestor's evidence is persuasive, the division will then review the evidence presented by the respondent to support that the amount paid was a fair and reasonable reimbursement for the disputed services.

   Review of the submitted documentation finds that:

   - The requestor billed the insurance carrier the amount of $45,411.57.
   - The insurance carrier issued a payment in the amount of $26,849.18.
   - The requestor seeks an additional payment of $19,685.88.
   - The division has not established a fee guideline for inpatient rehabilitation services.
   - The requestor submitted several redacted copies of EOBs in support of their fair and reasonable reimbursement argument.
   - The redacted copies of the EOBs reflect that Farmers and Sentry issued a payment at 100% of billed charges, with the exception of one EOB that shows a contracted reduction rate.
   - The division 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 alternative methods of reimbursement that use hospital charges as their basis. Such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 Texas Register 6268-6269).
   - While inpatient rehabilitation services are not the same as hospital care, the above principle is of similar concern here. 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.
   - Accordingly, 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 that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The submitted evidence does not support that a number of diverse payers found this amount to be an acceptable payment for the services in dispute.
   - The documentation does not support that the proposed payment achieves effective medical cost control while still ensuring the quality of medical care.
   - The documentation does not show that similar procedures provided in similar circumstances have received similar reimbursement.
   - The division finds the requested amount to not be consistent with the criteria of Labor Code §413.011.

- The division concludes the requestor has not satisfied the requirements of Rule §134.1

The request for additional reimbursement is therefore not supported. The division concludes the requestor has not discussed, demonstrated, and justified that 100% of billed charges is a fair and reasonable rate of reimbursement for the services in dispute.

3. The division concludes the requestor has not supported their request for additional reimbursement, whereas the respondent supported that they reimbursed the services at a fair and reasonable rate, by utilizing …"the Medicare rates for similar services provided in an in-patient setting by similar service provider, an inpatient hospital." Accordingly, additional reimbursement for the disputed services is not 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.

The DWC finds the requester has established that additional reimbursement of $0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 16, 2023 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.