TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
LAS PALMAS MEDICAL CENTER

Respondent Name
TRAVELERS INDEMNITY COMPANY OF AMERICA

MFDR Tracking Number
M4-23-2205-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
May 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26, 2022 through May 7, 2022	Inpatient Facility Charges Rehabilitation Services	$104,772.58	$0.00
	Total	$104,772.58	$0.00

Requestor's Position

"Hospital provided Inpatient Services in a CMS-certified Rehabilitation Facility spanning from 04/26/2022 through 05/07/2022 related to the patient's industrial injury... The services were provided in the Hospital's CMS-Licensed Rehabilitation Facility, which is exempt from the CMS \PPS reimbursement methodology and payable at reasonable rates. Please reference the medical records indicating the patient was receiving rehabilitation services in the exempt Hospital. Exempt services provided in an exempt unit are also identifiable on the attached original UB-04 form (Rehabilitation Facility NPI: 1942253398 located In field locator 56 and Taxonomy Code: 273Y00000X located in field locator 81CC)."

Amount in Dispute: $104,772.58

Requestor's Supplemental Position

"I am emailing on behalf of Las Palmar Medical Center regarding MFDR M4-23-2205-01. I received a fax today (file attached) requesting a response on whether or not we would like to continue our dispute resolution or withdraw as a result of additional payment. Travelers issued an additional $6,838.37, which we do not deem fair and reasonable. We would like to continue with dispute resolution."

Respondent's Position

"The Carrier has calculated the Medicare inpatient rehabilitation base rate of the admission as $19,144.54. Using the same inpatient modifier, the DWC has adopted for other inpatient hospital admissions of 143%, the Carrier has calculated fair and reasonable reimbursement to be $27,376.69. The Carrier issuing supplemental reimbursement in the amount of $6,838.37."

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 §134.1 sets out the medical reimbursement guidelines for fair and reasonable reimbursement.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- W3 – Bill is a reconsideration or appeal.
- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup.

Issues

1. What DWC rules and guidelines apply to the reimbursement for Rehabilitation Services?
2. Did the requestor support that the payment sought is a fair and reasonable rate of reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The subject of this disagreement is the reimbursement for rehabilitation services, for which the DWC has not established a medical fee guideline. The requestor billed a total of $125,310.90 for services rendered on April 26, 2022 through May 7, 2022. The insurance carrier issued a payment in the amount of $20,538.32 prior to the submission of the medical fee dispute process and paid an additional $6,838.37 after the submission of the medical fee dispute. The requestor seeks additional reimbursement of payment of the full billed charges.

   DWC's *Hospital Facility Fee Guideline—Inpatient*, Rule §134.403(f) determines reimbursement applying Medicare's OPPS formula and factors. This hospital's National Provider Identifier (NPI) number (field 56 on the bill) identifies the facility as a Rehabilitation Facility; as a result, reimbursement is not determined by applying the formula in Rule §134.403(f). The DWC finds that the dispute did not contain documentation to support a negotiated or contracted rate. Therefore, in the absence of an applicable fee schedule, Rule §134.403(e)(3) requires payment be determined according to Rule §134.1, regarding a fair and reasonable reimbursement.

2. This dispute regards inpatient rehabilitation services with reimbursement subject to the general medical reimbursement provisions of 28 TAC §134.1(e) and (f) states,

   (e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

   (1) the DWC's fee guidelines;
   (2) a negotiated contract; or
   (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.

   (f) 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 DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §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."

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) . . . when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds the following:

- The requestor's position statement states in pertinent part, "The services were provided in Hospital's CMS-Licensed Rehabilitation Facility, which *i*s exempt from the CMS \PPS reimbursement methodology and payable at reasonable rates."
- The DWC 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 DWC 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).
- To substantiate the assertion that the billed charges for rehabilitation services represent a fair and reasonable rate of reimbursement, the requestor provided copies of redacted EOBs. Although hospital care and rehabilitation services are not the same, the aforementioned principle is of similar concern here. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate of what insurance companies are paying for the same or similar services.
- Payment of the provider's billed charge is thus not acceptable when it leaves the payment amount in the health care provider's control — which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living.
- 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 requestor did not submit documentation to support how the requested additional payment would ensure the quality of medical care and achieve effective medical cost control.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1. The request for additional reimbursement is therefore not supported.

3. The requestor has failed to meet the requirements of DWC rules and the Labor Code. The requestor has the burden of proof at MFDR to support their request for additional reimbursement by a preponderance of the evidence. DWC concludes the requestor provided insufficient information to meet that burden. Consequently, 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 21, 2023 Date
Signature	Medical Fee Dispute Resolution, Director	December 21, 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.