



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MEMORIAL HOSPITAL SYSTEM

Respondent Name

ACIG INSURANCE COMPANY

MFDR Tracking Number

M4-23-2627-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

June 14, 2023

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|-------------------|------------|
| September 23, 2022 through December 2, 2022 | Inpatient Facility Charges Rehabilitation Services | \$285,278.70 | \$0.00 |
| Total | | \$285,278.70 | \$0.00 |

Requestor's Position

"This is an Inpatient Rehab bill for services provided by Memorial Hermann Hospital for a worker's comp injury for the above-named patient. As of right now, the inpatient medical bill is underpaid. It is underpaid as there is no fee schedule for Inpatient Rehab for Texas and there was no LOA done between the carrier and insurance company. Therefore, this bill should be paid at 100% of billed charges."

Amount in Dispute: \$285,278.70

Respondent's Position

"The Provider has failed to explain how the requested reimbursement is fair and reasonable or that it is consistent with Labor Code §413.011 by providing documentation of similar procedures provided in similar circumstances that received similar reimbursement. Apparently, the Provider believes that reimbursement at 100% of whatever it chooses to bill is fair and reasonable."

Response submitted by: Burns Anderson Jury & Brenner, L.L.P

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.
3. [28 TAC §134.404](#) sets out the inpatient hospital facility fee guidelines.

Denial Reasons

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

- BR (16) – The payment of this service is determined by report or by a report.
- BR– Claim/service lacks information or has submission/billing error(s).
- ZE (P12) – Your billing has been paid in accordance with the inpatient hospital fee schedule.
- ZE @G – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- Note – Reimbursement is based on Medicare IRF allowance.
- P12 #ZE – Workers' compensation medical treatment guideline adjustment.
- ZE (P12) – Workers' compensation jurisdictional fee schedule adjustment.
- @G (W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- T113 – Level 1 appeal means a request for reconsideration under 133.250.

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 provided in an inpatient setting. The requestor billed \$285,278.70 for services provided on September 23, 2022, through December 2, 2022. The insurance carrier issued a payment in the amount of \$95,179.30. The requestor seeks an additional payment of \$285,278.70.

TAC Rule §134.1 titled *Medical Reimbursement* 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.

The applicable fee guideline for inpatient services is TAC §134.404 which states in part "(1) This section applies to medical services provided in an inpatient acute care hospital." The requestor'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 §134.404. 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 §134.1(e) requires payment be determined according to Rule §134.1(f), 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(f) which states,

(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 Division 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, "...this bill should be paid at 100% of billed charges."
 - 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 requestor did not submit documentation to substantiate the assertion that the billed charges for rehabilitation services represent a fair and reasonable rate of reimbursement. 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

| | | |
|-----------|--|-------------------|
| | | December 21, 2023 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

| | | |
|-----------|--|-------------------|
| | | December 21, 2023 |
| Signature | Health and Safety, Deputy Commissioner | 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.