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
DEL SOL MEDICAL CENTER

Respondent Name
YSLETA ISD

MFDR Tracking Number
M4-23-2838-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
July 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 28, 2022 through July 13, 2022	Inpatient Facility Charges Rehabilitation Services	$208,278.10	$0.00
	Total	$208,278.10	$0.00

Requestor's Position

"Taking into account the bill is currently paid at a demonstrably incorrect rate, the previous reviews for services within the Hospital System indicating 80-100% of charges is fair and reasonable, the past Division medical dispute decision, and this bill is non-contracted, Hospital expects 100% of billed charges to be fair & reasonable. Please note, the amount requested on the attached reconsideration ($210,104.45) was submitted to Payer in an effort to expedite the resolution of this dispute in a timely manner and is not to be construed as Hospital's expectation for a fair and reasonable reimbursement. Payer's response failed to meet Hospital's offered discount from the fair and reasonable rate of 100% of charges. As such, Hospital requests for this bill to be reviewed and allowed in full at the fair and reasonable calculation below: $233,449.39 Billed Charges * 100% Reasonable Rate = $233,449.39 Expected Reimbursement."

Amount in Dispute: $208,278.10

Respondent's Position

"We received an inpatient Rehabilitation bill for the above claimant for DOS 6/28-7/13/2022. Although Texas Workers Compensation does not provide for a Fee Schedule for Inpatient Rehabilitation, CMS does provide a Repricer based on the facility, CMS number, CMG code and length of stay at https://webpricer.cms.gov/#/. This site was utilized to calculate the allowance for the bill in question. We have attached a copy of the bill, EOB/Check copies and CMS calculation for this inpatient Rehab billing."

Response submitted by: Claims Administrative Services, Inc. (CAS)

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 medical reimbursement guideline for inpatient acute care hospital services.

Denial Reasons

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

- 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology.
- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline.
- W3– In accordance with the TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.

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 dispute is the reimbursement for rehabilitation services provided in an inpatient setting from June 28, 2022, through July 13, 2022. The requestor billed the insurance carrier $233,449.39 and the insurance carrier issued a payment in the amount of $25,171.29. The requestor seeks an additional payment in the amount of $208,278.10.

   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 individuals 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, "$233,449.39 Billed Charges * 100% Reasonable Rate = $233,449.39 Expected Reimbursement."
- 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, 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 their assertion that the billed charges for rehabilitation services represent a fair and reasonable rate of reimbursement, the requestor provided copies of ten redacted Explanation of Benefits (EOBs) showing other workers' compensation insurance carriers paid for inpatient rehab services at full billed charges or at eighty percent of billed charges. The diagnosis codes and hence the diagnosis related-group codes from the EOBs were either redacted or for different codes. As the services paid at full billed charges or at eighty percent of billed charges in the requestor's example EOBs were for either different conditions or unknown, the EOBs do not support that the similar procedures provided in similar circumstances received similar reimbursement.
- 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.