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

General Information

Requester Name

Memorial Hermann Hospital System

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-24-029-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

October 4, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 21, 2023 – February 14, 2023	Inpatient Rehab	$177,801.25	$0.00
	Total	$177,801.25	$0.00

Requester's Position

"This is a bill for services provided by Memorial Hermann Hospital for a workers comp injury for the above name patient. As of right now, this bill has not been reprocessed for payment. We sent a reconsideration on 05/09/2023 and it was re-denied for 'incorrect carrier' when they are the correct carrier for the DOS."

Amount In Dispute: $177,801.25

Respondent's Position

"The provider's DWC 60 packet includes a letter pre-authorizing inpatient rehab. The date of the document is January 12 2023. It limits the inpatient rehab to 14 days… The carrier is reevaluating its position but the provider exceeded the preauthorization period unless the provider produces evidence of a concurrent review to extend the inpatient rehab beyond 14 days. Any monies owed

would be limited to the period covered by the preauthorization approval later dated January 13, 2023."

Response Submitted By: Flahive, Ogden and Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.1 defines medical reimbursement policies.
3. 28 TAC Section 134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- 310065 – This service was not pre-authorized in conformance with TWCC Rule 134.600

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the requester obtain preauthorization for the disputed inpatient services?
3. Is there a DWC fee guideline for Inpatient Rehabilitation Services?
4. Did the requester support the requested amount is fair and reasonable charge?

Findings

1. The requester is seeking reimbursement for inpatient services rendered on January 21, 2023 through February 14, 2023. The submitted medical bill indicates a bill type of 111 (inpatient service) in the amount of $177,801.25. The insurance carrier denied payment as service not pre-authorized.
2. The requestor included a copy of a "Texas Utilization Review" approval dated January 13, 2023 that states, "Inpatient Rehab. 14 days." Review of the submitted medical bill finds the length of stay was from January 21, 2023 through February 14, 2023 (24 days).

28 TAC Section134.600(c), states in pertinent part, “The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care."

28 TAC Section 134.600(p), “Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay…"

Documentation included in this file indicates authorization was obtained for fourteen units therefore, the applicable DWC rules and fee guideless will be applied to the charges for fourteen of the inpatient rehab days.

3. 28 TAC Section 134, Subchapter E, applies to health facility fees. Inpatient rehabilitation services are not identified in these rules.

   28 TAC Section 134.1(e) states, “Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (1) the Division'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.

   Review of the submitted medical bill and documentation has found there is no division fee guideline nor was there sufficient evidence to support a negotiated contract. The requirements of fair and reasonable reimbursement are found below.

4. 28 TAC Section 134.1(f) defines fair and reasonable reimbursement as a rate that:
   - Complies with Labor Code Section 413.011 criteria.
   - Ensures similar procedures in similar circumstances receive similar reimbursement; **and**
   - It is based on nationally recognized published studies, Division medical dispute decisions, and/or valuations for comparable services.

   Labor Code Section 413.011 mandates that fee guidelines be:
   - Fair and reasonable,
   - Promote quality care and cost control,
   - Encourage timely return to work, and
   - Avoid excessive payments compared to similar care for individuals with comparable standards of living.

   28 TAC Section 133.307 requires the requester 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 Section 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."

28 TAC Section 133.307 requires a position statement of the disputed issue(s) that should include:

(i) the requester's reasoning for why the disputed fees should be paid or refunded,

(ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and

(iii) how the submitted documentation supports the requester's position for each disputed fee issue.

Because no Division fee guideline or negotiated contract applies, the disputed services must be evaluated under the statutory and regulatory criteria for fair and reasonable reimbursement.

After a review of the submitted documentation and applicable standards, DWC finds that the requested reimbursement rate of $177,801.25 is not supported for the following reasons.

The requester did not provide documentation demonstrating that the billed charges for the disputed services reflect a fair and reasonable reimbursement rate as required under 28 TAC Section 134.1 and Labor Code Section 413.011.

A health care provider's "usual and customary" charges, standing alone, do not constitute evidence of a fair and reasonable reimbursement rate. Such charges do not establish what insurers customarily pay for the same or similar services in comparable circumstances.

Permitting reimbursement based solely on the provider's billed charges would effectively place payment determination within the provider's unilateral control. This outcome would be inconsistent with:

- The statutory objective of effective medical cost control, and
- The requirement that reimbursement does not exceed the amount paid for similar treatment of an injured individual of an equivalent standard of living, as contemplated by Labor Code Section 413.011.

Accordingly, usual and customary charges cannot be favorably considered absent additional objective data or documentation substantiating that the requested amount is fair and reasonable.

The requester did not submit documentation to demonstrate how the requested reimbursement:

- Ensures the quality of medical care, and

- Achieves effective medical cost control as expressly required by Texas Labor Code Section 413.011.

The statute requires that reimbursement methodologies balance adequate provider compensation with system-wide cost containment. No evidence was provided to establish that the requested $177,801.25 satisfies this statutory framework.

The requester did not provide:

- Nationally recognized published studies,
- Independent fee analyses,
- Benchmarking data, or
- Documentation of values assigned to services involving similar work and resource commitments to substantiate the requested reimbursement amount.

Without objective comparative data, the Division cannot determine that the requested rate aligns with fair market values for services requiring comparable time, skill, intensity, and resources.

The requester did not establish that payment of the requested amount satisfies the requirements set forth in 28 TAC Section 134.1, which governs reimbursement when no fee guideline applies. The documentation submitted does not demonstrate that the requested rate is reasonable within the context of the Texas workers' compensation system.

At the MFDR level, the requester bears the burden of proof to establish entitlement to reimbursement by a preponderance of the evidence.

DWC finds that the requester failed to submit sufficient documentation to support that the requested $177,801.25 constitutes a fair and reasonable reimbursement under applicable statutes and rules.

Because the evidentiary burden has not been met, payment cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

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

Authorized Signatures

Signature	Medical Fee Dispute Resolution Officer	June 24, 2026 Date
Signature	Director of Medical Fee Dispute Resolution	June 24, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.