SOAH DOCKET NOS. 454-21-3304.M4-NP & 454-21-3451.M4-NP
MRD NOS. _____& _____

NORTH TEXAS REHABILITATION CENTER,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
v.	§	
	§	
GREAT AMERICAN ALLIANCE INSURANCE COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

North Texas Rehabilitation Center (Provider) challenges decisions of the Texas Department of Insurance, Division of Workers' Compensation, Medical Review Division (MRD or Division) that denied Provider additional reimbursement from Great American Alliance Insurance Company (Carrier) for a program of interdisciplinary traumatic brain injury rehabilitation provided by Provider to (Claimant). In Docket No. 454-21-3451.M4-NP, Carrier argues that Provider failed to timely file its request for Medical Fee Dispute Resolution (MFDR) for claims with dates of service September 5-6, 2018. For the remaining claims in both dockets, Carrier argues that Provider is not entitled to additional reimbursement because the payments already made are consistent with fair and reasonable reimbursement, while Provider's reimbursement requests are not. The Administrative Law Judge (ALJ) agrees with both of Carrier's arguments and concludes that Provider is not entitled to additional reimbursement.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no contested issues of notice or jurisdiction; therefore, these matters are addressed in the Findings of Fact and Conclusions of Law without further discussion.

Provider timely requested hearings before the State Office of Administrative Hearings (SOAH). SOAH Joint Order No. 2, issued October 11, 2021, consolidated the dockets and set them for hearing. The hearing on the merits was held via Zoom videoconference on January 20,

2022, before ALJ Heather D. Hunziker. Provider appeared and was represented by Insurance Manager Catherine Zacharias. Carrier appeared and was represented by attorney Steven Tipton. The record closed on February 18, 2022, after the filing of written closing arguments.[1]

II. APPLICABLE LAW

The resolution of a fee dispute is regulated by the Division's billing, audit, and payment rules.[2] In an appropriate case, a health care provider, such as Provider, may dispute the amount paid by an insurance carrier.[3] In those cases, the Division's authority is limited to resolving "the amount of payment due for services determined to be medically necessary and appropriate."[4] The Division's rules reflect the statutory guidance and specify that:

In resolving disputes regarding the *amount of payment* for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to *adjudicate the payment*, given the relevant statutory provisions and division rules.[5]

A requestor, such as Provider, must timely file the request for MFDR with the Division's MFDR section or waive the right to MFDR.[6] Such a request must be "filed no later than one year after the date(s) of service in dispute."[7] Additionally, the requestor must provide documentation

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[1] SOAH Joint Order No. 3, issued January 27, 2022, held the record open for replies to closing arguments until February 18, 2022. Carrier filed its closing brief on February 4, 2022 (Closing Argument), and its reply brief on February 18, 2022; however, Provider filed no closing brief or response. Therefore, Carrier's reply brief was not considered by the ALJ. Similarly, Carrier's "Objections to Admission of [exhibits in Provider's response], and Motion to Disregard and Strike" filed February 24, 2022, is denied for mootness.

[2] *See* 28 Tex. Admin. Code (TAC) ch. 133. All citations in this Decision reflect the law applicable on the date of service for each claim.

[3] 28 TAC § 133.307.

[4] Tex. Labor Code § 413.031(c); 28 TAC § 133.307(a)(2).

[5] 28 TAC § 133.307(a)(2) (emphasis added).

[6] 28 TAC § 133.307(c)(1).

[7] 28 TAC § 133.307(c)(1)(A). Provider did not assert an exception under 28 TAC § 133.307(c)(1)(B).

that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with 28 Texas Administrative Code (TAC) § 134.1 when the dispute involves health care for which the division has not established a maximum allowable reimbursement or reimbursement rate, as applicable.[8]

Texas Labor Code § 413.011 sets forth reimbursement policies and guidelines and includes the following:

> (d) 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.

The Division rule that effects the above-referenced reimbursement guidelines is 28 TAC § 134.1 (Medical Reimbursement), which includes the following:

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

[8] 28 TAC § 133.307(c)(2)(O).

The party seeking relief has the burden of proof by the preponderance of the evidence.[9]

III. BACKGROUND, MFDR DECISIONS, EVIDENCE, ARGUMENT, AND ANALYSIS

A. Background

Claimant suffered a compensable injury on (Date of Injury).[10] On 38 days between May 7, 2018, and September 12, 2018, Claimant received interdisciplinary traumatic brain injury rehabilitation services from Provider, an outpatient rehabilitation facility, for the treatment of injuries sustained while on the job. The Division has not established a medical fee guideline for such services. For its services, Provider cited treatment code 97799 and billed Carrier $2,800 per service day, totaling $106,400.[11] Provider's documentation of services identified the varying types of, and amounts of time spent on, multidisciplinary therapies provided on each service date.[12] Carrier issued explanations of benefits (EOB) for the claims, approving a total of $35,859.38.[13] Carrier's EOBs explained that the workers' compensation jurisdictional fee schedule base rate was $720/day, and payment rates were calculated using allowances based upon whether the services rendered were cognitive rehabilitation, therapeutic exercises, biofeedback, group therapy, speech therapy, or individual counseling.[14] Carrier's EOBs explained the methodology as follows:

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[9] 28 TAC § 148.14(b); 1 TAC § 155.427. Burden of proof in worker's compensation insurance reimbursement cases determining fair and reasonable reimbursement was previously analyzed in great depth, in SOAH Docket No. 454-11-2417.M4 (consolidating 113 cases with the same basic legal issues and evidence) (affirmed as to burden of proof, reversed and rendered by the trial court in *Zurich American Ins. Co. v. Houston Community Hospital*, Cause No. D-1-GN-14-001325 in the 201st Judicial District Court of Travis County).

[10] Carrier Exs. A-1 at 1, B-1 at 1.

[11] Carrier Exs. A-3 at 7-41, B-3 at 9-11.

[12] Carrier Exs. A-5, B-5.

[13] Carrier Exs. A-4, B-4.

[14] Carrier Exs. A-4, B-4.

> Billed charges are for a brain injury program approved under non-specific code 97799. Texas currently has 4 program [sic] that are identified within the guidelines where this code is used. One of those programs is an Outpatient Medical Rehabilitation Program where Modifier Code MR is used and the rate for this program for a CARF[15] accredited facility is $90/hr. The head injury program being billed by [Provider] includes therapy/rehab hours that are reasonably the same as would be involved in this type of program. For the hours for rehab/therapy the Carrier … is using the same hourly rate for this CARF accredited facility. For more specific services that would not necessarily be included in such a program, and are more specific to this brain injury program the Carrier in an effort to find a Fair & Reasonable rate for these services has chosen to break these down by type of service performed as follows: Therapeutic Exercise: 97799 CARF Rehab Program x $90.00 per hour; Cognitive Rehab: G0515 $141.16 per hour; Biofeedback: 90902 $160.22 per hour; Group Therapy: 90853 $42.44 per hour; Speech Therapy: 92507 $125.71 per hour; Individual Counseling: 90837 $211.76 per hour.[16]

Provider requested reconsideration, in response to which Carrier denied additional payment.

B. MFDR Decisions

Provider filed two requests for MFDR, with different dates of service, for Claimant's outpatient rehabilitation. On April 19, 2019, Provider requested MFDR in Division File No. (DWC Number) (SOAH Docket No. 454-21-3304.M4-NP; MRD No. M4-19-3844-01) for 35 dates of service from May 7, 2018, to September 4, 2018.[17] On September 9, 2019, Provider filed for MFDR in Division File No. (DWC Number) (SOAH Docket No. 454-21-3451.M4-NP; MRD No. M4-20-0042-01) for three further dates of service: September 5, 2018; September 6, 2018; and September 12, 2018.[18] For each service date in its MFDR requests, Provider requested 100% of its billed charges of $2,800.[19]

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[15] CARF means Certified Accredited Rehabilitation Facility.

[16] Carrier Exs. A-4, B-4.

[17] Carrier Ex. A-1 at 1-2.

[18] Carrier Ex. B-1 at 1.

[19] Carrier Exs. A-1 at 1-2, B-1 at 1.

MFDR Decisions issued June 14, 2019, and October 4, 2019, found that Provider had failed to support its position that additional reimbursement was due.[20] Each MFDR Decision set forth certain statements of the Division regarding reimbursements based on hospital charges, as follows:

> 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 and rejected alternative payment methods that used hospital charges as their basis because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269).[21]

C. Evidence

Before the beginning of the hearing, the parties agreed that the operative facts in both cases were the same and the cases could be heard together. At the hearing, Provider offered no exhibits, but presented the testimony of its Insurance Manager, Catherine Zacharias. Carrier offered twelve exhibits, which were admitted, and presented the testimony of Senior Field Specialist and Adjuster, Spencer Spofford.

1. Testimony of Catherine Zacharias

Ms. Zacharias testified for Provider about its services and billing. She said Provider is a rehabilitation facility. Provider's brain injury program differs from other types of rehabilitation, in that it requires a minimum of five different disciplines of providers, which Ms. Zacharias said Provider can customize because Provider has twelve different types of providers. According to Ms. Zacharias, Provider customizes individual treatment for its patients and did so for Claimant.

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[20] Carrier Exs. A-6, B-6.

[21] Carrier Exs. A-6 at 295, B-6 at 35.

Ms. Zacharias testified that Claimant received hand and shoulder exercises, bicycle therapy for his back injuries, and other therapy. She explained that sometimes chronic pain patients and brain injury patients are in the same therapy group, but not "work hardening" patients. She stated that, although the exercises would typically be done by the entire group at once in this type of group program, Claimant's issues required personal one-on-one exercises.

Ms. Zacharias testified that Claimant was able to get back to a partial workday as a result of Provider's services, before he hit his head again, resulting in more significant brain injury. She said that Provider's health care providers were the ones to determine the best treatment for Claimant; and Provider met all the guidelines for these determinations.

On cross examination, Ms. Zacharias admitted that Provider is only CARF accredited in pain management and outpatient rehabilitation—not brain injury. She explained that "CARF" stands for Certified Accredited Rehabilitation Facility and requires recertification every three years through surveying of every policy and procedure.

Ms. Zacharias testified that Provider uses "cost plus cogs" pricing, which combines all of Provider's cost factors together. She said Carrier is the only insurance company that has not been able to agree with Provider on pricing—most other carriers are paying Provider 75 percent of what it is asking, not just 50 percent. She said Carrier wanted Provider to break down which treatments were given each day, but Provider was not prepared to separate the services provided because it is multidisciplinary.

2. Testimony of Spencer Spofford

Mr. Spofford is Carrier's handling adjuster for the underlying workers' compensation claim. He testified that Provider billed $2,800 per day on billing code 97799, which is a generic code for work hardening, chronic pain, and other types of treatment. He explained that $720 per day is the normal daily price for outpatient rehabilitation—not $2,800—although he acknowledged that another brain injury patient in the Dallas area had negotiated a rate of $765 per day for outpatient services.

Mr. Spofford said Provider had not accepted Carrier's fee schedule payment of $720 per day, so Carrier tried to break the payments down by which type of multidisciplinary therapies

were actually provided and use each of those individual modalities' fee schedules. To do so, Carrier had to match CPT[22] codes with the therapies given, then multiply those therapies' fee schedules by the number of hours. According to Mr. Spofford, Carrier did not question the number of hours Provider billed for; and Carrier paid the same amount per hour as it would have for CARF-certified multidisciplinary rehabilitation therapy, even though Provider is not CARF certified for brain injury.

Mr. Spofford listed Carrier's hourly reimbursement rates as follows: $141.16 for cognitive rehabilitation services, $90.00 for therapeutic exercises, $160.22 for biofeedback, $42.44 for group therapy, $211.76 for individual counseling, and $125.71 for speech therapy. According to Mr. Spofford, Carrier's methodology resulted in a different amount paid for each day, between $830 and the "mid-one-thousands," all of which were above the standard $720 per day (and the $765 per day agreed with the other Dallas provider referred to earlier). Mr. Spofford said the multidisciplinary fee schedule pays at $1000 per day, so some of Carrier's payments are even above that.

Mr. Spofford observed that there were no separate bills for room and board, which he attributed to Provider's services being on an outpatient basis; but he noted that Claimant was put up in a hotel near Provider's facility. Mr. Spofford said no claim was filed for room and board, as would be required for those items to be covered. However, on cross examination, he noted that Carrier is required to reimburse for lodging when a claimant must travel a certain distance or remain at the facility for a certain number of hours; and he conceded he was not aware that room and board was included in Provider's cost factor and considered in their $2,800 per day.

Mr. Spofford testified that Carrier's reimbursement rates are correct and reflective of the actual services provided on each specific date; whereas Provider's request for reimbursement of $2,800 per day was not based upon the specific services provided, which varied day to day. He said the reimbursements using Carrier's methodology are more than fair and reasonable.

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[22] This acronym was not defined.

D. Argument

In its Closing Argument, Carrier cited SOAH dockets that have rejected evidence of other payments to the Provider, alone, as satisfying the fairness and reasonableness factor of effective medical cost control.[23] Similarly, Carrier cited numerous SOAH dockets that have rejected using other carriers' payments to *other* providers, as evidence of the fairness and reasonableness factor of consistency with other reimbursement schemes.[24]

E. ALJ's Analysis

1. Claims with dates of service September 5-6, 2018

Provider failed to timely file for MFDR for claims on two service dates. Provider filed its request for MFDR on September 9, 2019, for its claims with service dates including September 5-6, 2018. Provider did not claim any exception applied to the one-year deadline to file a request for MFDR. Therefore, pursuant to 28 TAC § 133.307(c)(1), Provider waived its right to MFDR for these claims. Because Provider did not timely file a request for MFDR for the services provided September 5-6, 2018, Provider is not entitled to any additional reimbursement from Carrier for those claims.

2. All other claims

Claimant received interdisciplinary traumatic brain injury rehabilitation services from Provider on 36 dates between May 7, 2018, and September 12, 2018, exclusive of the two dates for which Provider waived its right to MFDR as discussed above. Payment is subject to the general medical reimbursement provisions of 28 TAC § 134.1(e) because the services were not provided through a workers' compensation health care network.[25] The Division has not

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[23] Carrier cites SOAH Consolidated Dockets No. 453-03-0143.M4, 453-03-3098.M4, 453-05-1535.M4 and 453-05-1536.M4, *Vista Healthcare, Inc. v. Twin City Fire Insurance Co.*, Decision and Order (June 12, 2007). Closing Argument at 7-8.

[24] Carrier cites SOAH Docket No. 453-01-179.M4, Decision and Order (January 23, 2002); Consolidated Dockets No. 453-03-0143.M4, 453-03-3098.M4, 453-05-1535.M4 and 453-05-1536.M4, *Vista Healthcare, Inc. v. Twin City Fire Insurance Co.*, Decision and Order (June 12, 2007); and SOAH Consolidated Dockets No. 453-03-0515.M4, 453-03-0516.M4, and 453-03-2818.M4, Decision and Order (June 27, 2007). Closing Argument at 8-9.

[25] 28 TAC § 134.1(e).

established a medical fee guideline for the type of services Provider provided Claimant and there was no negotiated contract for the services; therefore, reimbursement must be made in accordance with a fair and reasonable amount as specified in 28 TAC § 134.1(f).[26]

With its MFDR request, Provider was required to provide documentation to discuss, demonstrate, and justify that the payment amounts being sought were fair and reasonable rates of reimbursement in accordance with 28 TAC § 134.1.[27] Provider's documentation in evidence shows that the Claimant's treatments varied from day to day by type of therapy and time spent, and that Provider seeks payment of 100% of its billed charges of $2,800 per treatment day.[28]

It is Provider's burden to show that the reimbursement amount *sought* satisfies the Texas Labor Code's factors describing what is "fair and reasonable"; additionally, it is Provider's burden to show that the reimbursement amount *paid* by Carrier does *not* satisfy the statutory "fair and reasonable" factors. As explained below, Provider has failed to meet its burden on both accounts.

a. The preponderant evidence does not support a finding that the daily reimbursement amount Provider seeks is fair and reasonable.

Provider admitted no exhibits and made no argument; so, its position is supported only by Carrier's exhibits and the testimony of Ms. Zacharias. The record evidence is sparse as to Provider's billing methodology, citing only the generic billing code for work hardening, chronic pain, and other types of treatment; and including Claimant's treatment records. Provider's bills fail to explain why $2,800 per day was a fair and reasonable amount even though the amounts and types of treatment differed by the specific date of service.[29] Ms. Zacharias explained that Provider's pricing combines all the cost factors of its multidisciplinary treatment, so Provider could not separate the services provided. Ms. Zacharias also testified that other insurance companies have paid Provider 75 percent of what it billed.

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[26] 28 TAC § 134.1(e)(3).

[27] 28 TAC § 133.307(c)(2)(O).

[28] Carrier Exs. A-1, A-5, B-1, B-5.

[29] *Compare* Carrier Exs. A-3 with A-5; B-3 with B-5.

As noted in the MFRD Decisions, the Division has stated that reimbursement methodologies that use billed hospital charges, or a percentage thereof, as their basis do not provide acceptable fair and reasonable reimbursement amounts. While traumatic brain injury rehabilitation services are not the same as hospital care, this principle is of similar concern in this dispute. A health care provider's charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Unquestioning payment of a health care provider's billed charge would leave the determination of the payment amount in the provider's own hands, contrary to the objective of effective cost control and the standard not to pay more than for similar treatment of an injured individual of equivalent standard of living, both in Texas Labor Code § 413.011(d). In accordance with the Division's policy, neither the billed charges nor an amount based on a percentage of billed hospital charges can be considered to be a fair and reasonable reimbursement amount without further evidence. In the SOAH dockets cited by Carrier, discussed above, SOAH similarly rejected evidence of other payments to the provider, alone, as satisfying the fairness and reasonableness factor of effective medical cost control.

Neither Provider's evidence of its billed charges, nor Provider's evidence of other carriers' payments to it (which were, at most, 75 percent of its billing, not 100 percent) suffices to find Provider's requested reimbursement at 100 percent of Provider's $2,800 daily rate to be fair and reasonable. Therefore, Provider failed to show by a preponderance of the evidence that the daily reimbursement amount it seeks is fair and reasonable.

b. The preponderant evidence does not support a finding that the amount paid by Carrier is not fair and reasonable.

Provider failed to provide compelling evidence that the amount paid by Carrier was not fair and reasonable. On the contrary, the fairness and reasonableness of Carrier's payments were supported through numerous exhibits, testimony, and argument. The record evidence explains Carrier's reimbursement methodology in detail,[30] in which, as Mr. Spofford explained, Carrier used Provider's documentation of services to identify the types of multidisciplinary therapies

[30] *See* Carrier Exs. A-2, B-2 (Carrier's Responses to Requests for Dispute Resolution, explaining in detail how Carrier applied its methodology in its EOBs); Carrier Exs. A-4, B-4 (Carrier's EOBs).

actually provided on each service date and, using each of those individual modalities' fee schedules, multiplied the hourly fee by the number of hours to arrive at daily total amounts paid.

The daily amounts paid by Carrier, as listed in Provider's Request for MFDR and detailed in Carrier's EOBs,[31] exceed the workers' compensation jurisdictional fee schedule base rate of $720 per day for outpatient rehabilitation, and also exceed the $765 per day rate that Mr. Spofford testified was negotiated by another brain injury treatment provider in the area for outpatient services. Moreover, Carrier's payments to Provider for CARF-certified treatment, even though Provider lacks CARF certification for multidisciplinary brain injury treatment, are eminently fair and reasonable.

The methodology used by Carrier is consistent with the criteria of Texas Labor Code§ 413.011; ensures that similar procedures provided in similar circumstances receive similar reimbursement; and is based on values assigned for services involving similar work and resource commitments.

Provider failed to meet its burden, because it Provided no compelling evidence that Carrier's methodology resulted in an unfair or unreasonable reimbursement.

3. Conclusion

In conclusion, the ALJ finds that Provider waived MFDR for the services provided September 5-6, 2018, by its failure to timely file its request; therefore, Provider is not entitled to any additional reimbursement from Carrier for those services. Additionally, as to Provider's remaining claims for 36 further dates of service, the ALJ finds that Provider is not entitled to additional reimbursement because Provider failed to show, by the preponderance of the evidence, that: (1) the daily amount Provider seeks is fair and reasonable; and (2) the reimbursements already made by Carrier were not fair and reasonable.

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[31] Carrier Exs. A-1, B-1, A-4, B-4.

IV. FINDINGS OF FACT

1. (Claimant) suffered a compensable injury on (Date of Injury).

2. On the date of injury, Great American Alliance Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

3. On 38 days between May 7 and September 12, 2018, Claimant received outpatient interdisciplinary traumatic brain injury rehabilitation services from North Texas Rehabilitation Center (Provider), an outpatient rehabilitation facility, for the treatment of his injuries.

4. Provider billed Carrier $2,800 per service day, totaling $106,400, citing treatment code 97799, although the actual treatments varied from day to day.

5. Carrier issued explanations of benefits (EOB) for the claims approving a total amount of $35,859.38. The EOBs explained that payment rates were calculated above the workers' compensation jurisdictional fee schedule base rate of $720/day, using allowances based upon whether the services rendered were cognitive rehabilitation, therapeutic exercises, biofeedback, group therapy, speech therapy, or individual counseling.

6. Provider requested reconsideration; and Carrier denied additional payment.

7. On April 19, 2019, Provider filed a request for medical fee dispute resolution (MFDR) with the Texas Department of Insurance, Division of Workers' Compensation, Medical Review Division (MRD or Division), for Claimant's outpatient rehabilitation in Division File No. (DWC Number) (MRD No. M4-19-3844-01) for 35 dates of service from May 7, 2018, to September 4, 2018.

8. On September 9, 2019, Provider filed a request for MFDR with the Division, for Claimant's outpatient rehabilitation in Division File No. (DWC Number) (MRD No. M4-20-0042-01) for service dates of September 5, 2018; September 6, 2018; and September 12, 2018.

9. Provider failed to timely request MFDR within one year, for its services provided on September 5-6, 2018.

10. Provider timely requested MFDR of Carrier's denial with the Division, with respect to the 35 dates of service from May 7, 2018, to September 4, 2018, and September 12, 2018.

11. On June 14, 2019, and October 4, 2019, MFDR decisions were issued by the Division, finding that Provider had failed to support its position that additional reimbursement was due in MRD Nos. M4-19-3844-01 and M4-20-0042-01.

12. Provider timely requested hearings before the State Office of Administrative Hearings (SOAH) to contest the MFDR Decisions in favor of Carrier.

13. On August 19, 2021, the Division provided timely notice of hearing to Carrier and Provider in SOAH Docket No. 454-21-3304.M4-NP, concerning MRD No. M4-19-3844-01.

14. On August 31, 2021, the Division provided timely notice of hearing to Carrier and Provider in SOAH Docket Nos. 454-21-3451.M4-NP, concerning MRD No. M4-20-0042-01.

15. In SOAH Joint Order No. 2, issued October 11, 2021, the Administrative Law Judge (ALJ) consolidated SOAH Docket 454-21-3304.M4-NP with SOAH Docket 454-21-3451.M4- NP for docketing and procedural purposes, and set them to be heard and decided together.

16. The notices of hearing, together with Joint Order No. 2, included a statement of the time, place, and nature of the hearing; statements of the legal authority and jurisdiction under which the hearing was to be held; references to the particular sections of the statutes and rules involved; and attachments that incorporated, by reference, the factual matters asserted in the complaints or petitions filed with the state agency.

17. The hearing on the merits was held via Zoom videoconference on January 20, 2022, before SOAH ALJ Heather D. Hunziker. Provider appeared and was represented by Insurance Manager Catherine Zacharias. Carrier appeared and was represented by attorney Steven Tipton. Post-hearing briefing was submitted; and the record closed February 18, 2022.

18. At the beginning of the hearing the parties agreed that the operative facts were the same in both dockets, and that they could be heard and decided together.

19. Provider's services were not provided through a workers' compensation health care network.

20. The Division has not established a medical fee guideline for the type of services Provider provided Claimant and there was no negotiated contract for the services.

21. Provider seeks payment of 100% of its billed charges of $2,800 per treatment day.

22. The Division has stated that reimbursement methodologies that use billed hospital charges as their basis or that use a percentage of hospital billed charges as their basis do not provide acceptable fair and reasonable reimbursement amounts; and this principle applies equally to traumatic brain injury rehabilitation services.

23. Carrier's method of reimbursement: (1) identified the types of multidisciplinary therapy provided on each service date, as noted in Provider's documentation of services; (2) referred to each individual therapy modality's fee schedule; and (3) multiplied each therapy's hourly fee by the number of hours to arrive at daily total amounts paid.

24. The daily amounts paid by Carrier exceed the workers' compensation jurisdictional fee schedule daily base rate for outpatient rehabilitation and exceed the daily rate negotiated by another provider for similar services.

25. Carrier's reimbursement methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement and is based on values assigned for services involving similar work and resource commitments.

V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over these proceedings, including the authority to issue a decision and order, pursuant to Texas Labor Code § 413.0312(e) and Texas Government Code ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Texas Government Code §§ 2001.051-.052.

3. As the party seeking relief from the MFDR decisions, Provider had the burden of proving by a preponderance of the evidence that it had not been reimbursed a fair and reasonable amount by Carrier for the services provided and was entitled to additional reimbursement. 28 Tex. Admin. Code § 148.14(b); 1 Tex. Admin. Code § 155.427.

4. A requestor shall timely file the request with the Division's MFDR section or waive the right to MFDR. The request for MFDR must be filed no later than one year after the date(s) of service in dispute. 28 Tex. Admin. Code § 133.307(c)(1)(A).

5. The exceptions to the one-year filing deadlines set out in 28 Texas Administrative Code § 133.307(c)(1)(B) do not apply to Provider's claims for services provided Claimant on September 5-6, 2018.

6. Provider waived the right to MFDR as to dates of service September 5-6, 2018; therefore, Provider is not entitled to any additional reimbursement for medical services provided to Claimant on these dates. 28 Tex. Admin. Code § 133.307(c)(1)(A).

7. Because Provider's services were not provided through a workers' compensation health care network, payment is subject to the Division's general medical reimbursement provisions. 28 Tex. Admin. Code § 134.1(e).

8. Due to the absence of an applicable fee guideline or a negotiated contract, Provider's reimbursement must be made at *fair and reasonable* rates as specified in the Department's rules. 28 Tex. Admin. Code § 134.1(e)(3) (emphasis added).

9. Carrier's reimbursement methodology was consistent with the criteria of Texas Labor Code § 413.011; would ensure that similar procedures provided in similar circumstances receive similar reimbursement; and was based on values assigned for services involving similar work and resource commitments. Therefore, the methodology used by Carrier resulted in a fair and reasonable amount. 28 Tex. Admin. Code § 134.1.

10. Provider failed to show by a preponderance of the evidence that the daily reimbursement amount it seeks is fair and reasonable, and that Carrier's reimbursements were not fair and reasonable. Tex. Lab. Code § 413.011(d); 28 Tex. Admin. Code § 134.1.

11. Provider failed to show by a preponderance of the evidence that it is entitled to additional reimbursement for the services at issue in this proceeding.

ORDER

Provider is not entitled to additional reimbursement for services provided September 5-6, 2018, because Provider waived its claims for such services; and, as to its claims for all other service dates, Provider is not entitled to additional reimbursement because it was reimbursed fairly and reasonably.

NON-PREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 TAC § 133.307(h) require the non-prevailing party to reimburse the Division of Workers' Compensation for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires that SOAH identify the non-prevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, North Texas Rehabilitation Center is the non-prevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

SIGNED April 11, 2022.

HEATHER HUNZIKER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS