Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WOL + MED MEDICAL

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-05-2805-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
December 13, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment for date of service 02/12/2004 using PEC code F. (Fee). . . . This is an incorrect denial. We are CARF accredited and the fee is $125.00 an hour."

Amount in Dispute: $455.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Respondent's audit of these bills was correct and in accordance with the Fee Guidelines in effect at the time of the review."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Suite 100, Austin, Texas 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2004 to April 19, 2004	Chronic Pain Management	$455.00	$200.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The requestor submitted an amended Table of Disputed Services dated October 21, 2008, withdrawing previously disputed procedure code 64999 from consideration in this dispute. The Division will consider the remaining disputed services as indicated in the requestor's amended table as the basis for this review.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – FEE GUIDELINE MAR REDUCTION

Findings

1. This dispute relates to chronic pain management services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202(e)(5)(A)(I), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that " If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR." Additionally, §134.202(e)(5)(E) specifies that for "Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs (i) Program shall be billed and reimbursed using the "Unlisted physical medicine/rehabilitation service or procedure" CPT code with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (ii) Reimbursement shall be $125.00 per hour. Units of less than 1 hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes." Review of the submitted documentation supports that the services performed were chronic pain management. The requestor submitted documentation to support that the health care provider is CARF accredited. Documentation supports that there were eight hours billed of procedure code 97799-CP-CA. The Division specified fee is $125.00 per hour. The submitted documentation supports the services as billed. The total recommended reimbursement is $1,000.00.
2. The total recommended reimbursement for the services in dispute is $1,000.00. The insurance carrier has paid $800.00, leaving a balance due to the requestor of $200.00.

Conclusion

For the reasons stated above, the requestor has established that additional payment is due. As a result the amount ordered is $200.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $200.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 4, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.