



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

Denise Turboff, LPC

Respondent Name

Utica Mutual Insurance Co

MFDR Tracking Number

M4-07-8101-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

August 15, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In conclusion, our facility has billed these medical services accordingly and are to be reimbursed at \$100.00 per hour for a NON-CARF certified facility for the Chronic Pain Management program per the Medical Fee Guidelines."

Amount in Dispute: \$787.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dates of service April 4, April 9, and April 11, 2007 were reduced as Denise Turboff, LPC participates with a PPO contract through Aetna & her charges were reduced accordingly."

Response submitted by: Utica Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4 through 11, 2007	97799 – CP	\$787.50	\$787.50

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Manually Calculated PPO reduction

Issues

- Are the disputed services subject to a contractual agreement between the parties to this dispute?
- Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code d) In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s). The carrier denied the disputed charges as "Manually Calculated PPO reduction." No documentation was provided in regards to support that a reimbursement rate was negotiated between the worker's compensation insurance carrier and the health care provider prior to the services being rendered; therefore 28 Texas Administrative Code §134.202(d)(3) does not apply. The services in dispute will we reviewed per applicable fee guidelines.
2. Per 28 Texas Administrative Code §134.202(5) states, "Return to Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) Accreditation by the CARF is recommended, but not required. (A) 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 percent of the MAR. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. (5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 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. (B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." The total maximum allowable reimbursement is calculated as follows;

Date of Service	Submitted Code	Units	Billed Amount	MAR
April 4, 2007	97799 - CP	7	\$875.00	$\$125 \times 80\% = \$100 \times 7 = \$700.00$
April 9, 2007	97799 - CP	7	\$875.00	$\$125 \times 80\% = \$100 \times 7 = \$700.00$
April 11, 2007	97799 - CP	7	\$875.00	$\$125 \times 80\% = \$100 \times 7 = \$700.00$
		Total	\$2,625.00	\$2,100.00

The total MAR for the disputed services is \$2,100.00. The carrier previously paid \$1,312.50. The requestor is seeking \$787.50. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$787.50.

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 \$787.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 28, 2014
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.