



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

PATE REHAB

Respondent Name

HOUSTON ISD

MFDR Tracking Number

M4-11-0607-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

October 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the reconsideration request: "The claims were not processed per the Texas Work Comp Fee Schedule. Correcting by adding modifiers MR & CA are in compliance. Enclosed shows the Texas Dept of Insurance code of fee guideline that the standard is \$90 per hour. See rule 134.202 for Outpatient Rehabilitation Programs. We billed 97799 unlisted CPT code with the modifiers MR and CA. Six (6) hours for the units x 90 - \$540 per day. Rockport is the network we are contracted with that pay 85% leaving a 15% discount. There are no other discounts or reductions to be allowed."

Amount in Dispute: \$8,565.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted the bills for reimbursement for these services on UB-04s. As such, the Carrier audited the bills, as the services were performed inpatient. There are no Medical Fee Guidelines for inpatient rehabilitative services. As such, the Carrier reimbursed the services at the fair and reasonable rate of 28.7% of billed charges. The provider is requesting reimbursement based on Rule 134.202 (e) (5) (D), which is for outpatient medical rehabilitation programs. If these services were provided in an outpatient medical facility, then the provider has submitted the bills incorrectly. If the provider did provide these rehabilitative services inpatient in an acute care hospital, then respondent's position is that the reimbursement for the services was fair and reasonable."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12 through April 16, 2010	Outpatient Rehabilitation Hospital Services	\$2,039.50	\$2,039.50
April 19 through April 23, 2010		\$2,039.50	\$2,039.50
May 10 through May 14, 2010		\$1,631.60	\$1,631.60
May 24, 2010		\$407.90	\$407.90
June 1 through June 4, 2010		\$1,631.60	\$1,631.60
June 7 through June 8, 2010		\$815.80	\$815.80
TOTAL		\$8,565.90	\$8,565.90

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, effective June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, sets out the reimbursement guidelines for workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
 - PA – Prior Allowed
 - W1 – Workers compensation state fee schedule adjustment
 - Note – When billing on UB payment rate for rehab hospital is paid at fair & reasonable
 - 18 – Duplicate claim/service
 - DUP – Duplicate charge
 - 45 – Charge exceed your contracted legislated fee arrangement
 - Note – Paid per ratio 28.75%

Issues

1. Was the insurance carrier entitled to pay the healthcare provider at a contracted fee?
2. Did the requestor bill for an Outpatient Medical Rehabilitation Program?
3. What is the fee guideline for Outpatient Medical Rehabilitation Programs?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code “45 – Charge exceed your contracted legislated fee arrangement.” Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on May 30, 2012 the Division requested the respondent to provide a copy of the referenced contract as well as a documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment pursuant to the applicable Division rules and fee guideline.

2. Review of the UB04's submitted by the requestor document type of bill "743" in box 4 of the UB04. Per CMS the UB-04/CMS-1450 Reference Material identifies bill type "7-Clinic, 4 - Other Rehabilitation Facility (ORF), and 3 -Interim – Continuing Claims."

The requestor submitted sufficient documentation to support that the billing took place in an outpatient rehabilitation facility. As a result, this dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

3. Per 28 Texas Administrative Code §134.204 "(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "MR" 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 \$90 per hour. Units of less than one hour shall be prorated by 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 requestor seeks \$90/hour for 6 hours rendered on April 12, 2010, April 13, 2010, April 14, 2010, April 15, 2010 and April 16, 2010. The MAR reimbursement is \$540.00 x 5 dates of services = \$2,700.00. The insurance carrier issued payment in the amount of \$660.50; therefore the requestor is entitled to an additional reimbursement in the amount of \$2,039.50.

The requestor seeks \$90/hour for 6 hours rendered on April 19, 2010, April 20, 2010, April 21, 2010, April 22, 2010 and April 23, 2010. The MAR reimbursement is \$540.00 x 5 dates of services = \$2,700.00. The insurance carrier issued payment in the amount of \$660.50; therefore the requestor is entitled to an additional reimbursement in the amount of \$2,039.50.

The requestor seeks \$90/hour for 6 hours rendered on May 10, 2010, May 11, 2010, May 12, 2010 and May 14, 2010. The MAR reimbursement is \$540.00 x 4 dates of services = \$2,160.00. The insurance carrier issued payment in the amount of \$528.40; therefore the requestor is entitled to an additional reimbursement in the amount of \$1,631.60.

The requestor seeks \$90/hour for 6 hours rendered on May 24, 2010. The MAR reimbursement is \$540.00. The insurance carrier issued a payment in the amount of \$132.10; therefore, the requestor is entitled to an additional reimbursement in the amount of \$407.90.

The requestor seeks \$90/hour for 6 hours rendered on June 1, 2010, June 2, 2010, June 3, 2010 and June 4, 2010. The MAR reimbursement is \$540.00 x 4 dates of services = \$2,160.00. The insurance carrier issued payment in the amount of \$528.40; therefore the requestor is entitled to an additional reimbursement in the amount of \$1,631.60.

The requestor seeks \$90/hour for 6 hours rendered on June 6, 2010 and June 8 2010. The MAR reimbursement is \$540.00 x 2 dates of services = \$1,080.00. The insurance carrier issued payment in the amount of \$264.20; therefore the requestor is entitled to an additional reimbursement in the amount of \$815.80.

4. Review of the submitted documentation supports that the requestor is entitled to a total reimbursement amount of \$8,565.90, therefore 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 \$8,565.90.

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 \$8,565.90 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

Date

May 28, 2014

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.