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
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
HARTFORD INSURANCE COMPANY OF

MFDR Tracking Number
M4-13-0926-01

Carrier's Austin Representative
Number 47

MFDR Date Received
DECEMBER 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:"This program was approved on 4/3/12 (cert#711131358-1). The claim was submitted with the original HICF 1500 form, group notes, and supporting physical therapy notes for each date of service. Partial payment was received for the above mentioned dates of service. The carrier paid $25.00 for each date of service. This reimbursement rate issued by the carrier is completely inaccurate."

Amount in Dispute: $1,965.00

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 19, 2012. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2012 through April 16, 2012	97799-CP	$1,965.00	$1,125.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
3. Explanation of benefits were reduced/denied by the respondent with the following reason codes:
   - W1– Workers compensation state fee schedule adjustment.
   - 309- The charge for this procedure exceeds the fee schedule allowance.

- 193- Original payment decision is being maintained. This claim was processed properly the first time. 1014- The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the reimbursement guideline for CPT Code 97799-CP?

Findings

1. Per 28 Texas Administrative Code §134.204 "(h)The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of 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."

   Review of the CMS-1500s and the medical documentation finds that the requestor billed for the following;

   The requestor billed 8 hours of 97799-CP on April 11, 2012 and documented 4 hours. Reimbursement is calculated at $100.00/hour at 4 hours, minus the previous payment of $25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore $375.00.

   The requestor billed 8 hours of 97799-CP on April 12, 2012 and documented 4 hours. Reimbursement is calculated at $100.00/hour at 4 hours, minus the previous payment of $25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore $375.00.

   The requestor billed 8 hours of 97799-CP on April 16, 2012 and documented 4 hours. Reimbursement is calculated at $100.00/hour at 4 hours, minus the previous payment of $25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore $375.00.

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 $1,125.00.

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 $1,125.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 18, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).