



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

HEALTHTRUST

Respondent Name

INDEMNITY INSURANCE CO OF NORTH

MFDR Tracking Number

M4-13-1482-01

Carrier's Austin Representative

Number 15

MFDR Date Received

FEBRUARY 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review attached wherein HealthTrust has attempted several times to have these particular dates of service paid, and with each submission the adjuster claims that these dates have already been remitted. Each time a reconsideration is raised, EORs are given as "proof" that the claims have been paid. HealthTrust has asked for multiple times for copies of said checks that were suppose to be released to HealthTrust, however, the carrier has not been able to produce copies of those checks."

Amount in Dispute: \$14,589.00

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 February 21, 2013. 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
August 17, 2011 through February 8, 2012	90801, 96102, 97799-CP	\$6,789.00	\$0
February 13, 2012 through February 23, 2012	97799-CP	\$7,800.00	\$4,000.00
Total		\$14,589.00	\$4,000.00

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:
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - P1 – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility, unless the workers compensation state law allows the patient to be billed.
 - W1– Workers compensation state fee schedule adjustment.
 - QA – The amount adjusted is due to bundling or unbundling of services.
18-Duplicate claim/service.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for service dates August 17, 2011 through February 8, 2012?
2. What is the reimbursement guideline for CPT Code 97799-CP for service dates February 13, 2012 through February 23, 2012?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are August 17, 2011 through February 8, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 13, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

2. 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."

Per 28 Texas Administrative Code §134.204 "(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."

Review of the documentation submitted by the requestor finds that the requestor seeks reimbursement for CPT Code 97799-CP. The documentation does not reflect that the requestor appended modifier "CA."

As a result, 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 February 13, 2012 and documented 8 hours. Reimbursement is

calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 14, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 15, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 21, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 23, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

As a result the requestor is entitled to a total recommended amount of \$4,000.00 for dates of service February 13, 2012 through February 23, 2012.

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 \$4,000.00.

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 \$4,000.00 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).

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