



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 LLC

Respondent Name

ARCH INSURANCE CO

MFDR Tracking Number

M4-13-1939-01

Carrier's Austin Representative

Number 19

MFDR Date Received

APRIL 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The 97799-CP code is utilizing the "other-unlisted" code established by the CMS Medicaid/Medicare entity, however, with the addition of the CP modifier, the Texas rule overrides the unlisted code and thus the fee guideline is established. This code calls for an 8 hour (unit) per day and the reimbursement rate is established at \$125.00 per hour. As you can see from the amount reimbursed by your company, the payment is far less than that established by the state code. This fee reimbursement is mandated by the code and cannot be overridden by any carrier unless contract has been initiated with the provider. That is not the case here and reimbursement is expected in full."

Amount in Dispute: \$7,493.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerns billing under CPT 97799-CP and 96151 for service date 6/15/2012 to 7/30/2013. Carrier has issued payments that total \$500 for these service dates. Carrier asserts that it has correctly calculated reimbursement based upon the applicable fee guidelines and that there are no additional reimbursements owed."

Response Submitted by: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2012 through July 30, 2012	97799-CP	\$7,275.00	\$3,700.00
June 29, 2012	96151	\$218.28	\$0
TOTAL		\$7,493.28	\$3,700.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.

3. 28 Texas Administrative Code §134.600 sets out the procedures for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
4. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
5. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. Explanation of benefits were reduced/denied by the respondent with the following reason codes:
 - W1– Workers compensation state fee schedule adjustment.
 - QA – The amount adjusted is due to bundling or unbundling of services.
 - 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.
 - 171 – The charge was disallowed as it was not adequately identified.
 - 16 – Claim/service lacks information which is needed for adjudication.
 - 269 – A portion of the report is missing. Please resubmit with complete report.
 - MA – Medicare (jurisdictional regulatory requirement)
 - 255 – Please resubmit with a more appropriate CPT/HCPS code that better reflects services documented.
 - 29- The time limit for filing has expired.

Issues

1. What is the timely filing deadline applicable to service date June 29, 2012 for CPT Code 96151?
2. Did the requestor forfeit the right to reimbursement for the service date June 29, 2012 for CPT Code 96151?
3. What is the reimbursement guideline for CPT Code 97799-CP?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided. The requestor disputes CPT Code 96151 rendered on June 29, 2012. The insurance carrier's denial reason reduced/denied with reason code "29-the time limit for filing has expired."
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill for CPT Code 96151 rendered on June 29, 2012 was submitted within 95 days from the date the service. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement for CPT Code 96151 rendered on June 29, 2012, due to untimely submission of the medical bill for the service in dispute.
For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

3. 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 June 15, 2012 and documented 6.5 hours. Reimbursement is calculated at \$100.00/hour at 6.5 hours, minus the previous payment of \$125.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$525.00.

The requestor billed 8 hours of 97799-CP on June 26, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$125.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$675.00.

The requestor billed 8 hours of 97799-CP on June 28, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$125.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$675.00.

The requestor billed 8 hours of 97799-CP on June 29, 2012 and documented 7 hours. Reimbursement is calculated at \$100.00/hour at 7 hours, minus the previous payment of \$125.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$575.00

The requestor billed 8 hours of 97799-CP on June 30, 2012 and documented 7.5 hours. Reimbursement is calculated at \$100.00/hour at 7.5 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$725.00.

As a result the requestor is entitled to a total recommended amount of \$3,700.00 for dates of service June 15, 2012 through June 30, 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 \$3,700.00.

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 \$3,700.00 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

July 11, 2014
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).