



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

Pain & Recovery Clinic

Respondent Name

Hartford Fire Insurance Co

MFDR Tracking Number

M4-13-1990-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 8, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It seems inconceivable that a carrier can deny a medical bill for "timely filing" when the carrier was NOT the carrier on file during the time period that the services were billed."

Amount in Dispute: \$7,375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no written position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10 - 30, 2012	97799 - CP	\$7,375.00	\$1,100.00

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 medical fee disputes.
- 28 Texas Administrative Code §133.20 sets requirements of medical bill submission by health care providers.
- 28 Texas Administrative Code §134.204 sets out medical fee guidelines for Workers' Compensation specific services.
- 28 Texas Administrative Code §134.600 sets our requirements of prospective and concurrent review of healthcare.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment adjusted for absence of precert/preauth
 - 193 – Original payment decision maintained

Issues

- Did the respondent comply with Division rules in responding to medical fee dispute?

2. Did the requestor provide evidence of timely submission of claims?
3. Did the requestor support services were prior authorized?
4. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box, which was acknowledged as received on April 16, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division’s rule 28 Texas Administrative Code §133.307(d)(1), “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.” 28 Texas Administrative Code §133.307(d)(2)(G) states, “If the respondent did not receive the health care provider’s disputed billing or the employee’s reimbursement request relevant to the dispute prior to the request, the respondent shall include that information in a written statement.” The respondent submitted no such statement. Accordingly, this decision is based on the available information.
2. 28 Texas Administrative Code §133.20(b) states in pertinent part, “...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection(c) of the statute, the health care provider shall submit the medical bill to the correct workers’ compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider’s erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers’ compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.” Review of the submitted documentation finds;
 - a. The requestor submitted copies of the claims and pre-authorization determination #711132992-1.
 - b. The pre-authorization reflects CCMSI Dallas CCMSI Dallas as the Carrier. This notice is dated April 9, 2012, for dates of service April 9, 2012 through May 9, 2012.
 - c. The requestor submitted a certified mail receipt showing receipt of the services in dispute by CCMSI on March 6, 2013.

The division finds the requestor does not meet exception per Rule 133.20(b) as prior authorization request gave the requestor the correct carrier to submit claims to however documentation supports claims not sent to this carrier until 11 months later. There are no claims or EOMBS to support claims submitted to Sedgwick and denied due to timely filing as stated by the requestor.

3. 28 Texas Administrative Code §134.600(p)(5) states in pertinent part, “Non-emergency health care requiring preauthorization includes:... physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: ... (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; the claims supported by prior authorization number 711132992-1 and Explanation of Benefits that were denied for absence of pre-authorization can be reviewed per applicable rules and fee guidelines.
4. 28 Texas Administrative Code §134.204(h)(5)(B) states, “Reimbursement shall be \$125 per hour.” 28 Texas Administrative Code §134.204(h)(1)(B) states, “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.”

Date of service	Submitted Code	Units	Charges	MAR	Amount due
April 10, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 11, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 16, 2012	97799 CP	6	750.00	\$125 x 80% = \$100 x 6 units = \$600.00	\$600.00
April 17, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 18, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 23, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 24, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 25, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00
April 26, 2012	97799 CP	6	750.00	Not eligible for review	\$0.00

April 30, 2012	97799 CP	5	625.00	\$125 x 80% = \$100 x 5 units = \$500.00	\$500.00
		TOTAL	\$7,375.00	\$1,100.00	\$1,100.00

5. The total Maximum Allowable Reimbursement for the services in dispute is \$1,100.00. The carrier made reimbursement of \$0.00 leaving a balance due to the requestor of \$1,100.00

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 \$1,100.00.

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 \$1,100.00 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

June 5, 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).

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