



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

SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number

M4-13-3097-01

Carrier's Austin Representative

Number 01

MFDR Date Received

JULY 23, 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: \$10,140.00

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
October 29, 2012	97799-CP	\$1,560.00	\$0
November 2, 2012 through February 12, 2013	97799-CP	\$8,580.00	\$3,900.00
Total		\$10,140.00	\$3,900.00

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 §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
7. Explanation of benefits were reduced/denied by the respondent with the following reason codes:
 - 29- Time limit for filing claim/Bill has expired.
 - CP- Chronic pain management.
 - ORC- See additional information.
 - 193- Original payment decision maintained.
 - W1- Workers compensation state fee schedule adjustment.
 - B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - NC- Texas non CARF allowance @80%.
 - 150- Payment adjusted/unsupported service level.
 - B20- Svc partially/fully furnished by another provider.
 - 152- Payment adjusted/undocumented length svc.
 - 18-Duplicate claim/service.
 - R1- Duplicate billing.

Issues

1. What is the timely filing deadline applicable to the medical bill for service date October 29, 2012?
2. Did the requestor forfeit the right to reimbursement for service date October 29, 2012?
3. What is the reimbursement guideline for CPT Code 97799-CP for service dates November 2, 2012 through February 12, 2013?

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 on October 29, 2012.
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 was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for service date October 29, 2012.
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 November 2, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on November 8, 2012 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on November 9, 2012 and documented 7 hours. Reimbursement is calculated at \$100.00/hour at 7 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$300.00.

The requestor billed 8 hours of 97799-CP on December 11, 2012 and documented 4 hours. Reimbursement is calculated at \$100.00/hour at 4 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$0.

The requestor billed 8 hours of 97799-CP on January 23, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on January 30, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on February 4, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on February 5, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on February 7, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on February 8, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

The requestor billed 8 hours of 97799-CP on February 12, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$400.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$400.00.

As a result the requestor is entitled to a total recommended amount of \$3,900.00 for service dates November 2, 2012 through February 12, 2013.

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 \$3,900.00.

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 \$3,900.00 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 25, 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.