



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

BODIES IN BALANCE

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-13-3121-01

**Carrier's Austin Representative**

Number 19

**MFDR Date Received**

JULY 25, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We respectfully disagree with the reduction for payment on the above Mentioned Patient, please sent the reminding payment on the amount of \$19,500.00 for the services all ready preauthorized on this patient. "

**Amount in Dispute:** \$19,500.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2013 through May 29, 2013	97799-CP	\$19,500.00	\$10,025.00

#### 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.
- 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.
  - 247- a payment or denial has already been recommended for this service.
  - PI-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.
  - 309- The charge for this procedure exceeds the fee schedule allowance.
  - QA- The amount adjusted is due to bundling or unbundling of services.

## 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 15, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on April 17, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on April 18, 2012 and documented 5.75 hours. Reimbursement is calculated at \$100.00/hour at 5.75 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$550.00.

The requestor billed 8 hours of 97799-CP on April 19, 2013 and documented 5.75 hours. Reimbursement is calculated at \$100.00/hour at 5.75 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$550.00.

The requestor billed 8 hours of 97799-CP on April 22, 2013 and documented 3.75 hours. Reimbursement is calculated at \$100.00/hour at 3.75 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$350.00.

The requestor billed 8 hours of 97799-CP on April 23, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on April 25, 2013 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 26, 2013 and documented 6 hours. Reimbursement is calculated at \$100.00/hour at 6 hours, minus the previous payment of \$25.00 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 April 29, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 1, 2013 and documented 7 hours. Reimbursement is calculated at \$100.00/hour at 7 hours, minus the previous payment of \$25.00 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 May 8, 2013 and documented 6 hours. Reimbursement is calculated at \$100.00/hour at 6 hours, minus the previous payment of \$25.00 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 May 9, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 13, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 14, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 20, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 22, 2013 and documented 6 hours. Reimbursement is calculated at \$100.00/hour at 6 hours, minus the previous payment of \$25.00 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 May 23, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 24, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 28, 2013 and documented 5 hours. Reimbursement is calculated at \$100.00/hour at 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 \$475.00.

The requestor billed 8 hours of 97799-CP on May 29, 2013 and documented 6 hours. Reimbursement is calculated at \$100.00/hour at 6 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$575.00.

**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 \$10,025.00.

**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 \$10,025.00 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 , 2014 Date
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**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.**