



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

JTJ Marketing

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-13-3242-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 5, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "My complaint is that the carrier was paying for services but not according to the worker compensation fee schedule for Chronic Pain Program (CPT) 97799-CP-CA for a carf accredited facility."

Amount in Dispute: \$3,243.71

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."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17 – May 6, 2013	99799-CP-CA	\$3,243.71	\$3,237.47

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 §134.204 provides medical fee guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 309 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code
 - 45 – Charge exceeds fee schedule/maximum allowable or contacted/legislated fee arrangement
 - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor support fee guidelines not met?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied as, 309 – “Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.” Per 28 Texas Administrative Code §134.204(h)(1)(A) states, 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. (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. 28 Texas Administrative Code §134.204(h)(5) states, “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 submitted documents finds the carrier’s denial is not supported. Therefore, the disputed services will be reviewed per applicable fee guidelines.
2. The calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
April 17, 2013	97799-CP-CA	\$833.40	4	\$125 x 4 = \$500.00	31.25 + 28.13 = \$59.38	\$440.62
April 18, 2013	97799-CP-CA	\$625.05	3	\$125 x 3 = \$375.00	31.25 + 28.13 = \$59.38	\$315.62
April 19, 2013	97799-CP-CA	\$833.40	4	\$125 x 4 = \$500.00	31.25 + 28.13 = \$59.38	\$440.62
April 22, 2013	97799-CP-CA	\$833.40	4	\$125 x 4 = \$500.00	31.25 + 28.13 = \$59.38	\$440.62
April 23, 2013	97799-CP-CA	\$729.23	3.5	\$125 x 3 = \$375.00 + 62.50 = \$437.50	31.25	\$406.25
April 24, 2013	97799-CP-CA	\$729.23	3.5	\$125 x 3 = \$375.00 + 62.50 = \$437.50	31.25 + 28.13 = \$59.38	\$378.12
April 29, 2013	97799-CP-CA	\$833.40	4	\$125 x 4 = \$500.00	31.25	\$468.75
May 6, 2013	97799-CP-CA	\$729.23	3 **Handwritten (12) Carrier only considered 3. This number of units will be reviewed	\$125 x 3 = \$375.00	28.13	\$346.87
	Total	\$6,146.34		\$3,625.00	\$387.53	\$3,237.47

The total MAR is \$3,625.00. The amount paid (by EOB’s submitted with medical fee dispute) \$387.53. This leaves a balance of \$3,237.47. This amount is recommended.

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 \$3,237.47.

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 \$3,237.47 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 , 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.