



# 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**

Chronic Pain Recovery Center

**Respondent Name**

Seabright Insurance Co

**MFDR Tracking Number**

M4-14-0762-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 5, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The charges referenced herein were paid at a rate which is significantly below the Division of Worker's Compensation's prescribed fee schedule."

**Amount in Dispute:** \$7,562.50

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The carrier submits that all fee reductions were made in accordance with the applicable fee guidelines. No additional reimbursement is due."

**Response Submitted by:** Flahive Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2013 through May 10, 2013	97799-CP-CA	\$7,562.50	\$7,562.50

#### 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:
  - 790 – This charge was reimbursed in accordance to the Texas medical fee guidelines
  - 224 – Duplicate charge

#### **Issues**

- What is the applicable rule pertaining to reimbursement?
- Is the requestor entitled to reimbursement?

**Findings**

1. 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." 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 1, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	\$31.25	\$968.75
April 2, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	\$31.25	\$968.75
April 4, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	\$31.25	\$968.75
April 5, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	\$31.25	\$968.75
April 12, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	\$31.25	\$968.75
May 8, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	\$31.25	\$968.75
May 9, 2013	97799-CP-CA	\$1400.00	7	\$125 x 7 = \$875.00	\$0.00	\$875.00
May 10, 2013	97799-CP-CA	\$1400.00	7	\$125 x 7 = \$875.00	\$0.00	\$875.00
	Total	\$12,400.00		\$7,750.00	\$187.50	\$7,562.50

2. The total MAR for the services in dispute is \$7,750.00. The carrier previously paid \$187.50. The remaining balance is \$7,562.50. 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 \$7,562.50.

**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 \$7,562.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

		November , 2014
Signature	Medical Fee Dispute Resolution Officer	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.**