



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

HEALTHTRUST LLC

**Respondent Name**

INDEMNITY INSURANCE CO OF NORTH

**MFDR Tracking Number**

M4-14-1089-01

**Carrier's Austin Representative**

Number 15

**MFDR Date Received**

DECEMBER 13, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:**"HealthTrust received preauthorization for a total of 20 sessions of our multi-disciplinary chronic pain management program from the UR for the above mentioned patient. HealthTrust performed said treatments and billed the carrier for these services. Initially the carrier felt there were issues of relatedness, however, upon additional review the carrier made payment on the claims submitted. However, the carrier made payment in the amount of \$25.00 per date of service, clearly not the appropriate reimbursement amount as per the Texas Fee Guidelines."

**Amount in Dispute:** \$26,485.04

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:**"...Respondent has sent these bills back to audit for reconsideration of the amount paid. Once the reconsideration is completed the EOBs will be forwarded. For the CPT code 96151 billed for the date of service 2/7/13, the denial will stand. Requestor's documentation does not show that time was spent with Claimant face-to-face on this date for a re-assessment as required. Instead, Requestor simply summarized prior treatment. Additionally, Requestor billed for 8 hours of the chronic pain management program on the same date; therefore, there was no separate re-assessment of the Claimant performed on this date. As there was no separate service performed, additional reimbursement (beyond the payment for the 8 hours of chronic pain management) is not owed."

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2013 through March 6, 2013	97799-CP	\$26,170.00	\$13,250.00
February 7, 2013	96151	\$315.04	\$0
Total		\$26,485.04	\$13,250.00

**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 §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
3. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
4. 28 Texas Administrative Code §137.100 sets out the Treatment Guidelines.
5. Explanation of benefits were reduced/denied by the respondent with the following reason codes:
  - 309- The charge for this procedure exceeds the fee schedule allowance.
  - W1- Workers compensation state fee schedule adjustment.
  - QA- The amount adjusted is due to bundling or unbundling of services.
  - 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. Explanation of group codes for detail lines.
  - P1- 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.

## **Issues**

1. What is the reimbursement guideline for workers' compensation specific code 96151, for service date February 7, 2013?
2. What is the reimbursement guideline for CPT Code 97799-CP?

## **Findings**

1. Per 28 Texas Administrative Code §134.203 (a)Applicability of this rule is as follows: (1)This section applies to professional medical services provided in the Texas workers' compensation system, other than: (A)workers' compensation specific codes, services, and programs described in §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services)... (b)For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The workers' compensation carrier (carrier) denied services, in part, using claim adjustment code QA - which states that "The amount adjusted is due to bundling or unbundling of services."

Review of the documentation finds that the requestor billed code 96151 defined by the AMA CPT Code book as "Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment" and CPT code 97799-CP a division specific code for chronic pain management services.

Review of the submitted documentation finds that the requestor billed CPT codes 96151 and 97799-CP on February 7, 2013. No NCCI edits conflicts were identified between the division specific CPT code 97799-CP and CPT code 96151. As a result the division finds that the carrier's denial reason is not supported. The disputed charges are therefore reviewed pursuant to 28 Texas Administrative Code 134.600.

Per 28 Texas Administrative Code §134.600 "(p)Non-emergency health care requiring preauthorization includes:... (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier..."

Per 28 Texas Administrative Code §137.100 "(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

Review of the Office of Disability Guidelines (ODG) does not list code 96151 "Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment." As a result, CPT code 96151 required preauthorization per 28 Texas Administrative Code §134.600. Review of the documentation submitted by the requestor does not find that preauthorization was obtained for said services. For the reasons stated above, reimbursement for CPT Code 96151, service date February 7, 2013 is not recommended.

2. 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 January 31, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

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 \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

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 \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 6, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

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. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 11, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

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. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 18, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 19, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 20, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 21, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 25, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 26, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 27, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on February 28, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on March 5, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

The requestor billed 8 hours of 97799-CP on March 6, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours, minus the previous payment of \$25.00 as indicated by the requestor on the table of disputed services. The recommended amount is therefore \$775.00.

As a result the requestor is entitled to a total recommended amount of \$13,250.00 for service dates January 31, 2013 through March 6, 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 \$13,250.00.

**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 \$13,250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	July 25, 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).