



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

Nueva Vida Behavioral Health Associates, Inc

Respondent Name

City of San Antonio

MFDR Tracking Number

M4-14-1180-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Tri-Star Risk Management initially paid \$100.00 for each date of service. The reimbursement amount for each date of service should have been \$100.00 per unit."

Amount in Dispute: \$1,360.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In summary, the provider violated 28 TAC §133.250(d) by changing the billed amounts. Therefore, the initial reimbursement of \$200.00 is correct and no additional allowance is due."

Response Submitted by: Argus, 811 S. Central Expwy, Suite 440, Richardson, TX 75080

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6 – 7, 2013	97799 CP	\$1,360.00	\$1,360.00

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 medical fee disputes.
- 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for payment of medical bills.
- 28 Texas Administrative Code §134.202 sets out medical fee guidelines for professional medical services provided in the Texas Workers' Compensation system.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 193 – Original payment decision is being maintained
 - 198 – Precertification/authorization exceeded
 - W1 – Workers Compensation State Fee Schedule Adjustment/Reimbursement Rule

Issues

1. Did the requestor comply with division rules and guidelines in requesting reconsideration?
2. What is the applicable rule that determines fee guidelines?
3. Is the requestor entitled to reimbursement?

Findings

1. In their position statement the respondent states, "...the provider violated 28 TAC §133.250(d) by changing the billed amounts." 28 Texas Labor Code §§133.250. Reconsideration for Payment of Medical Bills.(d) A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier; (3) include any necessary and related documentation not submitted with the original medical bill to DWC Rules (4/1/2014) 28 TAC Chapter 133 23 of 56 support the health care provider's position; and (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment. Review of the submitted documentation finds;
 - a. Original claim 06/14/13 CMS 1500 (G) units submitted on line(s) 1 and 2 is (1).
 - b. Reconsideration from requestor dated July 10, 2013 where explanation of total number units and supporting group notes and physical therapy notes were included
 - c. Reconsideration from requestor dated November 12, 2013 states, "the correct billed amount was \$1400.00 for each date of service" ...we billed 8 units for each date of service."

The Division finds the requestor did provide a rational basis for modification of previous payment. The carrier's position is not supported. Therefore, the services in dispute will be calculated per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.202(5) states in pertinent part, "Return to Work Rehabilitation Programs. The following shall be applied 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... (i) 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% of the MAR. (ii) 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% of the MAR and 28 Texas Administrative Code §134.202(5)(E) states in pertinent part, ..." ii) Reimbursement shall be \$125.00 per hour."
3. The maximum allowable reimbursement (MAR) for 6-6-2013 is \$100 x 8 = \$800. The MAR for 6-7-2013 is \$800.00 for a combined total of \$1,600.00. The carrier previously paid \$200. The requestor is seeking \$1,360.00. 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 \$1,360.00.

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 \$1,360.00 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
-----------	--	---------------------

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.