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
Pain & Recovery Clinic

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-14-1351-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After numerous conversations with several individuals at Specialty Risk, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. We feel that our services were paid incorrectly and should be paid according to the fee schedule guidelines."

Amount in Dispute: $ 16,712.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's request was not date stamped as received by DWC MRD until 1/14/14. Consequently, it is not timely as to the DOS at issue earlier than 1/14/13 per Rule 133.307(c). The provider has failed to invoke the jurisdiction of DWC MRD as to these dates. …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
November 15, 2012 through January 31, 2013	97799 CP	$16,712.50	$3,850.00

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 medical fee disputes.
2. 28 Texas Administrative Code §134.204 provides medical fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - B13 – Previously paid

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are November 15, 16, 19, 20, 26, December 4, 6, 11, 17, 18, 19, 20, 2012 and January 10, 11, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on January 14, 2014. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of service.
2. 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." And "(5) 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. To qualify as a commission 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. Section 1 standards regarding Organizational Leadership, Management and Quality apply only to CARF accredited programs. (A) Accreditation by the CARF is recommended, but not required. (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." The calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
January 21, 2013	97799 CP	$875.00	7	125 x 80% = $100 x 7 = $700.00	$25.00	$675.00
January 22, 2013	97799 CP	$875.00	7	125 x 80% = $100 x 7 = $700.00	$25.00	$675.00
January 23, 2013	97799 CP	$812.50	6	125 x 80% = $100 x 6 = $600.00	$25.00	$575.00
January 28, 2013	97799 CP	$875.00	7	125 x 80% = $100 x 7 = $700.00	$25.00	$675.00
January 29, 2013	97799 CP	$812.50	6	125 x 80% = $100 x 6 = $600.00	$25.00	$575.00
January 31, 2013	97799 CP	$875.00	7	125 x 80% = $100 x 7 = $700.00	$25.00	$675.00
	Total	$5,125.00		$4,000.00	$150.00	$3,850.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for disputed services from which MFDR was requested within one year from the date of service. As a result, the amount ordered is $3,850.00.

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 $3,850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December 4, 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.