



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 North

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-14-2039-01

Carrier's Austin Representative Box

Box Number 05

MFDR Date Received

March 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After filing a reconsideration and still being denied as "these services have already been considered for reimbursement", it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized."

Amount in Dispute: \$2,698.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the dates in questions and agrees the Provider is entitled to supplemental reimbursement. The Carrier disagrees, however, with the amount on dispute south by the Provider in the Table of Disputed Services. Based on the Carrier's review, supplemental reimbursement in the amount of \$1,187.50 is due under the Division-adopted fee schedule. Supplemental reimbursement in that amount is being issued to the Provider."

Response submitted by: Travelers Indemnity Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2013 - December 18, 2013	97799 CP	\$2,698.00	\$549.25

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 a medical fee dispute.
- Texas Administrative Code §134.204 sets out reimbursement guidelines for Workers Compensation specific services.
- The services in dispute were denied/reduced with the following reasons;
 - 863 – Reimbursement is based on the applicable reimbursement fee schedule
 - 247 – Duplicate service

Issues

1. Did the requestor support claim for additional reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(h)(1)(B) states, “ 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.” Texas Administrative Code §134.204(h) (5)(A)(B) 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.
 - (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 documentation submitted finds;

Date of Service	Billed amount	Number of units	MAR (125 x 80% x number of units)
November 15, 2013	\$812.50	6.5	\$100 x 6 = \$600 2 (15 minute increments to equal half an hour) x 32.50 = \$65.00 \$600 +65.00 = \$665.00
December 13, 2013	\$750.00	6	\$100 x 6 = \$600.00
December 16, 2013	\$812.50	6.5	\$100 x 6 = \$600 2 (15 minute increments to equal half an hour) x 32.50 = \$65.00 \$600 +65.00 = \$665.00
December 17, 2013	\$750.00	6	\$100 x 6 = \$600.00
December 18, 2013	\$750.00	6	\$100 x 6 = \$600.00
	\$3,875.00	Total MAR	\$3,130.00

Total allowable equals \$3,130.00.

2. The total recommended payment for the services in dispute is \$3,130.00. This amount less the amount previously paid by the insurance carrier of \$1,175.00 (plus \$1,187.50 paid as response to MFDR) or \$2,362.50 leaves an amount due to the requestor of \$549.25. 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 \$549.25.

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 \$549.25 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

October , 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.