



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

Elite Healthcare Garland

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-14-3417-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dates of service 10/28/2013, 11/06/2013, and 01/16/2014 has been denied due to "The time limit for filing has expired." The time limit has not expired being the carrier sent payment (see attached) but it was incorrect."

Amount in Dispute: \$2,583.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bills in question have been paid. The EOBs are attached and as well as screen shots to show the payments."

Response Submitted by: Broadspire, 8827 W. Sam Houston Parkway N. Suite 110, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2013	97002	\$69.18	\$1,539.99
October 15, 2013	97799	\$800.00	
October 28, 2013	97799	\$800.00	
November 6, 2013	97799	\$800.00	
January 16, 2014	99213	<u>\$114.45</u>	
		\$2,583.63	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 sets out the reimbursement guidelines for professional services.

3. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for Workers' Compensation specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Explanation of benefits dated January 28, 2014
 - W1 – Workers’ compensation jurisdictional fee schedule adjustment

Explanation of benefits dated March 31, 2014

- 18 – Exact duplicate claim/service
- D10 – The time limit for filing has expired

Explanation of benefits dated July 29, 2014

- 648-099 Texas bill reconsideration
- 683 – Reimbursement has been calculated according to the state fee schedule guidelines
- 983-001 – Upon further review – additional payment is warranted

Explanation of benefits dated November 13, 2013

- 598 – the reimbursement for this procedure has been calculated according to the guidelines for a program that is not CARF accredited
- W1 – Workers’ compensation jurisdictional fee schedule adjustment

Explanation of benefits dated January 24, 2014

- 790 – the charge was reimbursed in accordance to the Texas medical fee guideline
- W1 – Workers’ compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier’s reasons for reduction of payment supported?
2. What is the applicable rule pertaining to Workers Compensation specific services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the disputed services with claim adjustment reason code W1 – “Workers’ compensation jurisdiction fee schedule adjustment.” 28 Texas Administrative Code §134.203 (c) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

Review of the submitted information finds that Codes 97002 for date of service September 24, 2013 and 99213 for date of service January 16, 2014 are both Professional Services subject to Rule 134.203(c). The maximum allowable reimbursement (MAR) is calculated as follows;

Date of Service	Submitted Code	Submitted Charge	(DWC Conversion Factor / Medicare Conversion Factor) x Non-facility amount= MAR	Carrier Paid
September 24, 2013	97002	\$69.18	$(55.3/34.023) \times \$40.17 = \65.29	\$69.18
January 16, 2014	99213	\$114.45	$(55.75/35.8228) \times \$69.61 = \108.33	\$114.45
		TOTAL	\$173.62	\$183.63

The insurance carrier's reduction reason is supported. Therefore additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code 134.204 (h) states in pertinent part

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.

The remaining services in dispute are for Code 97799 for dates of service October 28, 2013 and November 6, 2013. The carrier reduced the services in dispute as W1 – "Workers' compensation jurisdictional fee schedule adjustment."

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 MAR is calculated as follows;

Date of Service in Dispute	Submitted Code	Submitted Charge	MAR calculation \$125 x 80% x number of units	Carrier Paid
October 15, 2013	97799	\$800.00	125 x 80% = \$100 x 8 units = \$800	\$800.00
October 28, 2013	97799	\$800.00	125 x 80% = \$100 x 8 units = \$800	\$25.00
November 6, 2013	97799	\$800.00	125 x 80% = \$100 x 8 units = \$800	\$25.00
	Total	\$2,400.00	\$2,400.00	\$850.00

3. The total allowable for the services in dispute is \$2,573.62 (\$173.62 + 2,400.00). The amount previously paid by the Carrier that is supported by explanation of benefits is \$1,033.63. The remaining balance of \$1,539.99 is due to the requestor. 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 \$1,539.99.

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 \$1,539.99 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	August , 2015 Date
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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, 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 MFDR 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.