



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

PRC Health Services, LLC

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-14-3419-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

July 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has recently received EOBs denying payment for authorized treatment due to "workers compensation jurisdictional fee schedule adjustment."

Amount in Dispute: \$6,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines."

Response submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12- 26, 2013 September 5 – 16, 21013	97799 CP	\$6,750.00	\$5,400.00

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 a medical fee dispute.
- 28Texas Administrative Code §134.204 sets out reimbursement guidelines for Workers Compensation specific services.
- 28Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
- The services in dispute were denied/reduced with the following reasons;
 - W1 – Worker's Compensation Jurisdictional fee schedule adjustment
 - 197 – Precertification/authorization/notification absent
 - 216 – Based on the findings of a review organization

Issues

- Did the respondent maintain denial based on review organization findings?

2. Did the requestor support claim is dispute were prior authorized?
3. Is the requestor entitled to reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that “The carrier asserts that it has paid according to applicable fee guidelines.” Review of the Explanation of Benefits from the Carrier finds use of 216 – “Based on the findings of a review organization.” –The division concludes that the respondent did not maintain their denial reason. For that reason, the denial for 216 – “Based on the finds of a review organization,” shall not be considered in this review.
2. The carrier denied some of the disputed services as, 197 – “Precertification/authorization/notification absent.” 28 Texas Administrative Code §134.600(p) states in pertinent part, “Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation;” Review of the submitted documentation finds;
 - a. Zurich Service Corporation document dated July 19, 2013
 - b. Additional Services Authorized: chronic pain management
 - c. Current Authorization Period: 07/19/2013 – 09/19/2013 (80 hours)
 - d. Authorization number: 130430-274070-001

The carrier’s denial is not supported as shown above the services in dispute were prior authorized. The disputed services will be reviewed per applicable rules and fee guidelines.

3. 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)
August 12, 2013	\$500.00	4	\$100 x 4 = \$400.00
August 13, 2013	\$812.50	6.5	\$100 x 6 = \$600 + 100 ÷ 4 = 25.00 x 2 = \$50 \$600 + \$50= \$650.00
August 15, 2013	\$812.50	6.5	\$100 x 6 = \$600 + 100 ÷ 4 = 25.00 x 2 = \$50 \$600 + \$50= \$650.00
August 20, 2013	\$812.50	6.5	\$100 x 6 = \$600 + 100 ÷ 4 = 25.00 x 2 = \$50 \$600 + \$50= \$650.00
August 21, 2013	\$812.50	7	\$100 x 7 = \$700.00
August 23, 2013	\$812.50	6.5	\$100 x 6 = \$600 + 100 ÷ 4 = 25.00 x 2 = \$50 \$600 + \$50= \$650.00
August 26, 2013	\$812.50	6.5	\$100 x 6 = \$600 + 100 ÷ 4 = 25.00 x 2 = \$50 \$600 + \$50= \$650.00
September 5, 2013	\$812.50	6.5	\$100 x 6 = \$600 + 100 ÷ 4 = 25.00 x 2 = \$50 \$600 + \$50= \$650.00
September 16, 2013	\$500.00	4	\$100 x 4 = \$400.00
Total	\$6,750.00		\$5,400.00

The total recommended payment for the services in dispute is \$5,400.00. This amount less the amount previously paid by the insurance carrier of \$0 leaves an amount due to the requestor of \$5,400.00. 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 \$5,400.00.

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 \$5,400.00 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	October 23, 2014 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, 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.