



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

Pain & Recovery Clinic – North

Respondent Name

Hartford Fire Insurance Company

MFDR Tracking Number

M4-15-2613-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor.

Amount in Dispute: \$1750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found that the Requestor was authorized to treat up to 80 hours of pain management. Start Date 10/22/14 End date 12/22/14.

The Requestor has been reimbursed in excess of 80 hours during this timeframe (please see enclosed supportive documentation), thus, no addition reimbursement is warranted."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12 & 13, 2014	Chronic Pain Management (97799-CP)	\$1750.00	\$1300.00

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 §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. 28 Texas Administrative Code §133.210 sets out the requirements for medical documentation with medical bills.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 483 – Medical report required for payment.
 - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Does a preauthorization issue exist for the disputed services?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. In their position statement, the insurance carrier states that "The Requestor has been reimbursed in excess of 80 hours" which was the extent of the preauthorization. 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Review of the submitted documentation does not find a denial for preauthorization on the Explanations of Benefits for the dates of service in dispute. Therefore, this is a new issue and will not be considered in this review.
2. The insurance carrier denied disputed services with claim adjustment reason code 483 – "Medical report required for payment." 28 Texas Administrative Code §133.210 (c) states, in relevant part, "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates"

Review of the submitted information finds medical documentation for the disputed services. Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.204 (h)(5) states, in relevant part, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (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." Review of the submitted documentation finds that the requestor is seeking reimbursement for 7 hours for each of the dates of service in question. However, documentation supports 6.45 hours for each date of service in question, which equates to 6.5 units each. Therefore, the MAR is \$812.50 for date of service November 12, 2014 and \$812.50 for date of service November 13, 2014.
4. 28 Texas Administrative Code §134.204 (h)(1) states, "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." Review of the submitted documentation finds that the requestor billed with CPT Code 97799 and program modifier 'CP' only. Therefore, the hourly reimbursement is 80 percent of the MAR.

The total MAR for the disputed services is \$1625.00. The allowable 80 percent of MAR for the disputed services is \$1300.00. The insurance carrier has paid \$0.00. Therefore, an additional reimbursement of \$1300.00 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 \$1300.00.

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 \$1300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 28, 2015
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, 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.