



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
ULTIMATE PAIN SOLUTIONS

Respondent Name
INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-15-3023-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have called Ms. Watson on several occasions and left voice messages but have never received a return call. It is for these reasons that I am asking for assistance from the MFDR department."

Amount in Dispute: \$12,270.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR request, the bills were sent for review. Payments for all dates of service have been issued. Attached are copies of the EORs and payment screens."

Response Submitted by: ACE Esis

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include service dates from May 10, 2014 to June 16, 2014, with corresponding service codes and amounts.

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 §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division specific services.
4. 28 Texas Administrative Code §134.1 sets out the Medical Reimbursement policies for fair and reasonable reimbursement.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W11 & P6 – Entitlement to benefits.
 - 1 – Patient has been discharged from care, no further treatment is authorized.
 - 2 – Adjusters request no allowance was made.
 - 2 – This procedure on this date was previously reviewed.
 - 3 – Duplicate claim/service.
 - 5 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
 - 16 – Claim/service lacks information or has submission/billing error(s), which is needed for adjudication.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for date of service May 10, 2014?
2. Did the insurance carrier issue payment per 28 Texas Administrative Code §134.204, for the non-CARF work hardening program rendered on June 2, 2014 through June 18, 2014?
3. Did the insurance carrier issue payment per 28 Texas Administrative Code §134.203, for CPT Codes 90791?
4. Did the requestor submitted documentation to meet the requirements of 28 Texas Administrative Code §134.1 for CPT Code 97799 x 2?
5. Is the requestor entitled to additional 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 date of the services in dispute is May 10, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 18, 2015. This date is later than one year after the date(s) 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 the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due for this service. As a result, the amount ordered is \$0.00.

2. 28 Texas Administrative Code §134.204 (h)(1) 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. (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.”

28 Texas Administrative Code §134.204 (h)(3) states, “(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier ‘WH.’ Each additional hour shall be billed using CPT Code 97546 with modifier ‘WH.’ CARF accredited Programs shall add ‘CA’ as a second modifier. (B) Reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.”

Review of the submitted documentation (CMS-1500's) document that the requestor billed CPT Codes 97545-WH and 97546-WH. No documentation was submitted to support that the disputed services are CARF accredited and the disputed charges did not contain the –CA modifier on the CMS 1500's presented for review. As a result, the requestor is entitled to 80% of the MAR for these services.

Review of the CMS-1500's document that the requestor billed 2 hours of CPT Code 97545-WH and 6 hours of CPT Code 97546-WH for dates of service 6/2/14, 6/5/14, 6/9/14, 6/11/14, 6/16/14, and 6/17/14. Review of the CMS-1500's document that the requestor billed 2 hours of CPT code 97545-WH for dates of service June 10, 2014 and June 18, 2014.

Review of the submitted documentation finds that the requestor documented the following hours for each disputed date of service:

June 2, 2014, the requestor billed 8 of work hardening and documented 7.45 hours. The MAR amount is \$51.20/hour and \$12.80/15 minute increment, for a total MAR of \$396.80. The insurance carrier issued a payment in the amount of \$409.69, as a result, no additional reimbursement is recommended.

June 5, 2014, the requestor billed 8 of work hardening and documented 7 hours. The MAR amount is \$51.20/hour, for a total MAR of \$358.40. The insurance carrier issued a payment in the amount of \$409.69, as a result, no additional reimbursement is recommended.

June 9, 2014, the requestor billed 8 of work hardening and documented 6.45 hours, the MAR amount is \$51.20/hour and \$12.80/15 minute increment , for a total MAR of \$345.60. The insurance carrier issued a payment in the amount of \$409.69, as a result, no additional reimbursement is recommended.

June 11, 2014, the requestor billed 8 of work hardening and documented 6.45 hours, the MAR amount is \$51.20/hour and \$12.80/15 minute increment , for a total MAR of \$345.60. The insurance carrier issued a payment in the amount of \$409.69, as a result, no additional reimbursement is recommended.

June 16, 2014, the requestor billed 8 of work hardening and documented 7.45 hours. The MAR amount is \$51.20/hour and \$12.80/15 minute increment, for a total MAR of \$396.80. The insurance carrier issued payment a in the amount of \$409.69, as a result, no additional reimbursement is recommended.

June 17, 2014, the requestor billed 8 of work hardening and documented 7.15 hours, the MAR amount is \$51.20/hour and \$12.80/15 minute increment, for a total MAR of \$371.20. The insurance carrier issued payment a in the amount of \$409.69, as a result, no additional reimbursement is recommended.

June 10, 2014, the requestor billed 2 hours of CPT Code 97546 and documented 2 hours, the MAR amount is \$51.20/hour, for a total MAR of \$102.40. The insurance carrier issued a payment in the amount of \$102.49, as a result, no additional reimbursement is recommended.

June 18, 2014, the requestor billed 2 hours of CPT Code 97546 and documented 2 hours, the MAR amount is \$51.20/hour, for a total MAR of \$102.40. The insurance carrier issued a payment in the amount of \$102.49, as a result, no additional reimbursement is recommended.

3. The requestor seeks reimbursement for CPT Code 90791 rendered on May 19, 2014. Review of the EOB's submitted by the insurance carrier support that a payment in the amount of \$210.61 was issued to the requestor.

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 \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

The MAR reimbursement for CPT code 90791 is \$210.61. The insurance carrier issued a payment in the amount of \$210.61, as a result, no additional reimbursement is recommended for this CPT code.

4. The requestor seeks reimbursement for CPT Codes 97799, which represents an “unlisted physical medicine/rehabilitation service or procedure”, a professional medical service subject to 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203 (f) states, pertinent part, “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204 (f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title.” The disputed CPT Code does not have an established relative value unit or payment assigned by Medicare or Texas Medicaid. Accordingly, reimbursement is determined pursuant to 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement.

28 Texas Administrative Code §134.1 requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection (f), which states that Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments if available.

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title ... when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable. Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor’s position statement does not provide a rationale for increased reimbursement from the insurance carrier.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for CPT Code 97799. As a result, reimbursement cannot be recommended for CPT Code 97799 rendered on June 5, 2014 and June 16, 2014.

5. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services..

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 30, 2015

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.