



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 AND RECOVERY CLINIC

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-16-1527-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The adjuster Milagros Ramirez has failed to produce EOB'S as required by rule 133.240 in the Texas Administrative Code and we are requesting a waiver for the extent of injury denials and request that the bills be audited per TDI."

Amount in Dispute: \$14,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that for the initial review of the charges, Utilization and Peer Review had denied the services as not authorized. After a second review, the charges were authorized and payments will now be made to the provider's satisfaction at billed charges, fee schedule or at the amount expected by the medical provider. I have included copies of the Explanation of Benefits for your review."

Response Submitted by: Rising Medical Solutions, Inc.

Respondent's Supplemental Position Summary: "The carrier moves to stay this MDR proceeding until the extent of injury dispute is resolved."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 11, 2015 Through December 4, 2015; Chronic Pain Management Program - CPT Code 97799-CP-CA; \$14,250.00; \$10,937.50

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled Medical Fee Guideline for Workers' Compensation Specific Services, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 02/22/2016: We recently received you appeal request regarding he above referenced bill. Based on our review, we are recommending an additional payment be made to your facility.

Issues

1. Does an extent of injury issue exist?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the respondent's supplemental position summary **"The carrier moves to stay this MDR proceeding until the extent of injury dispute is resolved."**

28 Texas Administrative Code §133.307(d)(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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

A review of the submitted explanation of benefits does not list any denial reasons to support the issues raised in the supplemental position summary; therefore, the extent of injury issue is a new issue and will not be addressed any further in this decision. The Division finds that the response was not submitted in accordance with 28 Texas Administrative Code §133.307. As a result, the disputed services will be reviewed per applicable Division rules and guidelines.

2. The respondent also indicated in the original position summary that "After a second review, the charges were authorized and payments will now be made to the provider's satisfaction at billed charges, fee schedule or at the amount expected by the medical provider. I have included copies of the Explanation of Benefits for your review."

The Division reviewed the submitted explanation of benefits that indicated payment was issued for dates of service September 11, 2015 through September 24, 2015. No explanation of benefits were submitted for dates of service December 1, 3 and 4, 2015.

On April 13, 2016, the Division contacted the requestor's representative Anna Hernandez to verify that payment was received and that services remained in dispute. Ms. Hernandez stated that payment was received for all dates of service except September 16, 17, 18, 22, October 2, 13, 20, 23, 29, November 3, 12, 13, 19, 23, December 1 and 3, 2015 that remained unpaid and in dispute.

28 Texas Administrative Code §134.204(h)(1)(A) states "(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."

28 Texas Administrative Code §134.204(h)(5)(A) and (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. 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 Division finds that the requestor billed CPT code 97799-CP-CA for a total of 87.5 hours on September 16, 17, 18, 22, October 2, 13, 20, 23, 29, November 3, 12, 13, 19, 23, December 1 and 3, 2015. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is \$125.00 per hour x 87.5 hours = \$10,937.50. The carrier paid \$0.00. Therefore, the difference between the MAR and amount paid is \$10,937.50. This amount is recommended for reimbursement.

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 \$10,937.50

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 \$10,937.50 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

Date

04/21/2016

YOUR RIGHT TO REQUEST AN 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.