



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Pain and Recovery Clinic – North

**Respondent Name**

Zurich American Insurance Company

**MFDR Tracking Number**

M4-16-3504-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

July 21, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for fee schedule allowance."

**Amount in Dispute:** \$375.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOB(s) and the reduction rationale(s) stated therein."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2016	Chronic Pain Management	\$375.00	\$375.00

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment.

**Issues**

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

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

Review of the submitted documentation finds that the requestor billed and supported 4 units/hours of chronic pain management and billed using the "CA" modifier. Therefore, the MAR for these services is \$500.00.

2. The total MAR for the disputed services is \$500.00. The insurance company paid \$0.00. An additional reimbursement of \$375.00 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 \$375.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$375.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 11, 2016 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.**