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
NORTH TEXAS REHABILITATION CENTER

Respondent Name
GREAT AMERICAN ALLIANCE INSURANCE

MFDR Tracking Number
M4-18-2877-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There was a dispute of MMI and IR and a Benefit Contested Case Hearing was scheduled, and decision reached, attached to this letter is the decision... Yet after the decision, the carrier has not paid and we need your assistance in this collection effort."

Amount in Dispute: $64,400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the carrier denied payment for the dates of service per the adjuster. The basis of the denial was that the request was for treatment unrelated to the compensable injuries... While the services provided were preauthorized, Carrier is not prohibited from denying payment for those services as not being related to the compensable injury... Based on the foregoing, the carrier asks that requestor's request for reimbursement be denied."

Response Submitted by: The Silvera Firm

SUMMARY

Dates of Service	Disputed Service	Amount In Dispute	Dismissal
April 10, 2017 through May 17, 2017	97799-CA	$64,400.00	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the Medical Bill Submission by Health Care Provider.
3. 28 Texas Administrative Code §134.204 sets out the division specific professional fee guidelines.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
    - 270 – Denied as per adjuster
    - 270 – No allowance has been recommended for this procedure/service/supply

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor waive the right to medical fee dispute resolution for dates of service April 10, 2017, April 11, 2017 and April 12, 2017?
3. Are the insurance carrier's denial reasons supported?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Code(s) 97799-CA rendered on April 10, 2017 through May 17, 2017. The insurance carrier in the position summary states in pertinent part, "The basis of the denial was that the request was for treatment unrelated to the compensable injuries..."

   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."

   The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary, "The basis of the denial was that the request was for treatment unrelated to the compensable injuries...," are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060 request. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review. The disputed services are therefore reviewed pursuant to the applicable rules in affect for the disputed services.

2. The requestor seeks reimbursement for medical services rendered on April 10, 2017, April 11, 2017 and April 12, 2017. 28 Texas Administrative Code §133.307(c) (1) states in pertinent part, "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 dates of the services in dispute are April 10, 2017, April 11, 2017 and April 12, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 13, 2018. 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 dates of service April 10, 2017, April 11, 2017 and April 12, 2017.

3. The requestor seeks reimbursement for CPT Code 97799-CA as indicated on the medical bills, (CMS-1500's) and the Table of Disputed Services, rendered on April 13, 2017 through May 17, 2017. The insurance carrier's denied the disputed services with denial reduction code "16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

   28 Texas Administrative Code §134.204 states in pertinent part, "(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs--This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited. (2) CP, Chronic Pain Management Program--This modifier shall be added to CPT Code 97799 to indicate Chronic Pain Management Program services were performed... (4) MR, Outpatient Medical Rehabilitation Program--This modifier shall be added to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed."

28 Texas Administrative Code §134.204 (h) states in pertinent part, The following shall be applied to...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...

- (4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "MR" 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 $90 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 eight minutes and less than 23 minutes.
- (5) 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.

28 Texas Administrative Code 133.20 states in pertinent part, "(c) A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

Review of the submitted documentation, CMS-1500's, EOB's document that the requestor billed CPT Code 97799-CA to identify that the services rendered were CARF accredited. The Division however, identified that the requestor did not append the required modifier as identified in 28 Texas Administrative Code §134.204 (n). The reimbursement differs depending on which modifier is appended to CPT Code 97799. The Division therefore finds that the requestor did not identify which service was rendered and therefore has not met the requirements of 28 Texas Administrative Code §134.204 (n) and §133.20 (c). As a result, reimbursement for the disputed services cannot be recommended.

4. Review of the submitted documentation finds that insurance carrier's denial reason is supported. As a result, the requestor is not entitled to reimbursement for the disputed services rendered on April 13, 2017 through May 17, 2017.

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 5, 2018 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.