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
NUEVA VIDA BEHAVIORAL HEALTH ASSOCIATES, INC

Respondent Name
SAN ANTONIO WATER SYSTEM

MFDR Tracking Number
M4-19-1555-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On January 30, 3018 Nueva Vida Behavioral Health faxed 2 claims with multiple dates of service (12/1/17-12/11/17 and 11/15/17-11/29/17)…The confirmation page shows all the pages went through successfully."

Amount in Dispute: $4,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider did not timely submit its medical bills to the carrier pursuant to §408.027 of the Texas Labor Code and Division rule 133.20(b). The provider is not entitled to reimbursement."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2017 through December 11, 2017	CPT Code 97799-CP (48 hours)	$4,800.00	$4,800.00

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, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.

2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Was the request for medical dispute resolution timely filed with the division?
2. Did the requestor support position that the disputed bills were submitted timely to the insurance carrier?
3. Is the requestor due reimbursement for CPT code 97799-CP?

Findings

1. This dispute involves dates of service November 15, 2017 through December 11, 2017. The dispute was filed to TDI-DWC MFDR on November 16, 2018. TDI-DWC addresses the issue as follows:
   - The requestor performed the service in San Antonio, Texas .
   - San Antonio, Texas is located in Bexar County.
   - On August 23, 2017, Governor Greg Abbott issued a proclamation declaring that Hurricane Harvey poses a threat of imminent disaster along the Texas Coast and in numerous counties including Bexar County. The declaration states in pertinent part: "THEREFORE, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, I do hereby declare a state of disaster in the previously listed counties based on the existence of such threat. Pursuant to Section 418.017 of the code, I authorize the use of all available resources of state government and of political subdivisions that are reasonably necessary to cope with this disaster. Pursuant to Section 418.016 of the code, any regulatory statute prescribing the procedures for conduct of state business or any order or rule of a state agency that would in any way prevent, hinder or delay necessary action in coping with this disaster shall be suspended upon written approval of the Office of the Governor. However, to the extent that the enforcement of any state statute or administrative rule regarding contracting or procurement would impede any state agency's emergency response that is necessary to protect life or property threatened by this declared disaster, I hereby authorize the suspension of such statutes and rules for the duration of this declared disaster."
   - Governor Abbott issued subsequent proclamations extending the state of disaster for the named counties due to the substantial destruction in South, Central and East Texas. To date, the Hurricane Harvey Disaster Proclamations cover a period from August 23, 2017 through January 10, 2018 for Bexar County.
   - The Texas Department of Insurance issued Commissioner's Bulletins# B-0020-17 and B-0042-17 as a result of the Governor's Proclamation. The bulletins "required insurance carriers to continue to process and pay workers' compensation claims and tolled (paused) deadlines for specified workers' compensation procedures involving system participants who reside in the counties listed in the Governor's disaster proclamation."
   - Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
   - In this dispute, 28 Texas Administrative Code §133.307(c)(1)(A), is computed by ***counting*** each

day up to and including August 23, 2017, then by ***NOT counting*** each day from August 24, 2017, through January 9, 2018, and finally by counting of days from January 10, 2018 and on. In other words, the total days would be computed by adding only the days counted before, and the days counted after the tolled period, not to include any of the days in the tolled period.

MFDR's obligation under the Governor's Proclamations and the Commission's Bulletins is to accept dates of service November 15, 2017, as timely because the one-year dispute filing deadline, in this case, is tolled.

2. According to the submitted explanation of benefits, the respondent denied reimbursement for the chronic pain management program based upon reason codes "29-The time limit for filing has expired," and "4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service."

   To determine if CPT code 97799-CP is eligible for reimbursement the division refers to the following statute:

   - Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   - 28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   - 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The division reviewed the documentation and finds:

   - Fax Confirmation Image Reports dated January 30, 2018 for dates of service November 15, 2017 through November 29, 2017, December 1, 2017 through December 11, 2017, and December 13, 2017 through December 15, 2017. These reports indicate that the bills for the above listed dates of service were faxed to the same number "12102334104".
   - The requestor wrote that dates of service December 13, 2017 through December 15, 2017 were not in dispute because the insurance carrier paid them.
   - The respondent did not refute the above listed fax number was theirs.

   The division finds the requestor supported position that the disputed bills were submitted within the 95 day deadline per Texas Labor Code §408.027(a).

3. The fee guideline for chronic pain management services, CPT code 97799-CP, is found in 28 Texas Administrative Code §134.230.

   28 Texas Administrative Code §134.230(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 maximum allowable reimbursement (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 §134.230(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.

The division reviewed the submitted documentation and finds:

- The requestor billed for a non-CARF accredited chronic pain management program with code 97799-CP.
- The requestor is seeking dispute resolution for 48 hours of CPT code 97799-CP rendered from November 15, 2017 through December 11, 2017.
- Per 28 Texas Administrative Code §134.230(1) and (5), the following formula is used to calculate the MAR: 80% of $125.00 = $100.00 X 48 hours = $4,800.00. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $4,800.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4,800.00.

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 $4,800.00 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	12/19/2018 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.