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
NEURO RESTORATIVE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-5078-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received a denial for missing CPT code which was fixed and resent and for duplicate multiple times incorrectly. This claim has been billed as requested by TX Mutual and are still being denied. Attached please find all of the submissions that were made to Texas Mutual, along with the UB04 and authorization."

Amount in Dispute: $18,525.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual first received a bill from NEURORESTORATIVE on 10/01/2018 [sic] for disputed dates of service. The bill was denied as the facility did not include appropriate cpt codes on the bill as necessary for reimbursement on outpatient facility bill. NEURORESTORATIVE submitted a 'corrected' bill on 2/4/19 in which they added cpt code 97127. The addition of the cpt code makes it a new bill and therefore did not meet the 95-day rule from date of service per Rule 133.20(b)... The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 1, 2018 through November 30, 2018	Revenue Code 240, CPT 97127	$18,525.00	$18,525.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out the procedures for Medical Bill Submission by Health Care Provider.
3. 28 TAC §134.1 sets out the Medical Reimbursement Policies.
4. TIC (TIC) §1305 applicable to Health Care Certified Networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 725 – Approved non network provider for Texas Star Network claimant per rule 1305.153 (C)
   - 894 – HCPCS/CPT codes required to determine MAR; services are not reimbursable as billed
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule

Issue(s)

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. 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?
3. Are the disputed services subject to reimbursement pursuant to 28 TAC 134.1?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for revenue code 240, CPT Code 97127, rendered on November 1, 2018 through November 30, 2018, to an injured employee enrolled in the Texas Star Network, a certified healthcare network. The insurance carrier's response indicates that the claim is in the Texas Star Network. The requestor seeks a decision from the DWC's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider.

   The insurance carrier denied/reduced the disputed charges with denial reason code "725 – Approved non network provider for Texas Star Network claimant per rule 1305.153 (C)."

   The requestor filed this medical fee dispute to the DWC asking for resolution pursuant to 28 TAC (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the DWC to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the TIC, Chapter 1305 and limited application of TLC statutes and rules, including 28 TAC §133.307.

   Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Review of the "Out of Network Authorization to Treat Injured Worker Covered by the Texas Star Network," dated August 9, 2018, documents that the requestor, NeuroRestorative, obtained an out-of-network approval to treat the in-network injured employee. The out of network referral states in pertinent part, "The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved. This approval is limited specifically to the provider named above and does not extend to other associates or services within a practice group or business entity. The extent of treatment to be provided as the approved out-of-network provider is limited to the referral consultation and/or services not available within the network."

   TIC §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   The DWC's medical fee dispute resolution section may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so. The DWC finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(3). As a result, the disputed services are under the jurisdiction of the DWC and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to TIC §1305.153(c).

2. The requestor billed revenue code 240, CPT Code 97127 rendered on November 1, 2018 through November 30, 2018. The insurance carrier in the position summary states in pertinent part, "NEURORESTORATIVE submitted a 'corrected' bill on 2/4/19 in which they added cpt code 97127. The addition of the cpt code makes it a new bill and therefore did not meet the 95-day rule from date of service per Rule 133.20(b)..."

28 TAC §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, "...did not meet the 95 day rule from date of service per Rule 133.20(b)..." is not a denial reason raised during the medical bill review process, as it is 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 was 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 DWC; therefore, the DWC 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.

3. The requestor seeks reimbursement for revenue code 240 rendered on November 1, 2018 through November 30, 2018. The requestor obtained an out of network referral, pursuant to TIC §1305.153 (c), which indicates that a provider who provides care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

   The services in dispute are for outpatient cognitive rehabilitation services subject 28 TAC §134.1(e) which states that payment for health care shall be made in accordance with the applicable DWC fee rule or by applying a negotiated contract rate. In the absence of an applicable fee guideline or a negotiated contract, the payment is subject to the DWC's general fair and reasonable reimbursement methodology described in §134.1(f). Review of the documentation finds a copy of a negotiated contract. The fees agreed upon by the parties therefore apply. See 28 TAC §134.1(e)(2).

   The requestor provided a copy of a settlement agreement and release, which states in pertinent part, "2. Payment, Texas Mutual will pay NEURORESTORATIVE $975.00 per day for its Day Treatment Program." The DWC finds that the requestor is therefore entitled to reimbursement for disputed dates of service:

Disputed DOS	Contracted Amount	Amount Recommended
November 1, 2018,	$975.00/day	$975.00
November 2, 2018	$975.00/day	$975.00
November 6, 2018	$975.00/day	$975.00
November 7, 2018	$975.00/day	$975.00
November 8, 2018	$975.00/day	$975.00
November 9, 2018	$975.00/day	$975.00
November 12, 2018	$975.00/day	$975.00
November 13, 2018	$975.00/day	$975.00
November 14, 2018	$975.00/day	$975.00
November 15, 2018	$975.00/day	$975.00
November 16, 2018	$975.00/day	$975.00
November 19, 2018	$975.00/day	$975.00
November 20, 2018	$975.00/day	$975.00
November 21, 2018	$975.00/day	$975.00
November 26, 2018	$975.00/day	$975.00
November 27, 2018	$975.00/day	$975.00
November 28, 2018	$975.00/day	$975.00
November 29, 2018	$975.00/day	$975.00
November 30, 2018	$975.00/day	$975.00
Total:	$18,525.00	$18,525.00

4. The DWC finds that the requestor is entitled to reimbursement in the amount of $18,525.00, for the reasons stated above. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $18,525.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $18,525.00 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 6, 2019
Signature	Medical Fee Dispute Resolution Officer	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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.