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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PRIDE

Respondent Name
FIDELITY & GUARANTY INSURANCE

MFDR Tracking Number
M4-12-0309-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are seeking full reimbursement for the outstanding balance of $2137.50 along with any interest accrual that we are entitled according to the rule 134.803. The total amount willed was $3840.00 and the amount received was $712.50 that is why we have an outstanding balance of $2137.50."

Amount in Dispute: $2,137.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated October 28, 2011: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Respondent's Supplemental Position Summary dated March 9, 2012: "The carrier is in the process of trying to obtain a copy of the requested contract."

Respondent's Supplemental Position Summary dated March 26, 2012: "**Please see the attached fax confirmation that shows that a copy of the contract was provided by fax on 3/22/12**."

Responses Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2010	CPT Code 97799-CP-CA (8 units) Chronic Pain Management	$2,137.50	$762.50

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 medical fee disputes.
2. 28 Texas Administrative Code §134.204 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - 15-(150)-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 45-(45)-Charges exceed your contracted/legislated fee arrangement.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Is the requestor entitled to reimbursement for chronic pain management services?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On February 17, 2012, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

   28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

   The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. According to the explanation of benefits, the respondent reduced the payment for CPT code 97799-CP-CA based upon reason code "15". The requestor submitted documentation to support billed program; therefore, reimbursement per Division fee guideline is recommended.

   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 8 units on September 28, 2010. Therefore, per 28 Texas Administrative Code §134.204(h)(5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour. $125.00 times 8 hours billed is $1,000.00. According to the submitted explanation of benefits, the respondent paid $237.50 for the disputed date of service. The difference between the MAR and amount paid is $762.50. This amount is recommended for additional 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 $762.50.

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 $762.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		6/4/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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

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