



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

PAIN & RECOVERY CLINIC OF NORTH HOUSTON

Respondent Name

AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number

M4-18-5084-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier failed to produce payment in timely fashion. We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: \$875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bills in question for manual review to determine if any monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: September 13, 2017, Chronic Pain Management: 97799-CP-CA, \$875.00, \$875.00

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

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.230 sets out guidelines for Return to Work Rehabilitation services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 1 - PROCEDURE STATUS CODE C FROM CMS RVU
- 2 - NO REDUCTION AVAILABLE
- 3 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 4 - W3 - Request for reconsideration.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards chronic pain management services with reimbursement subject to the *Medical Fee Guideline for Return to Work Rehabilitation Programs*, 28 Texas Administrative Code §134.230(5)(A) requiring the program be billed using code 97799 with modifier "CP." CARF accredited programs shall add "CA" as a second modifier. Per Rule §134.230(5)(B), reimbursement shall be \$125 per hour, prorated to the nearest 15-minute increment. Rule §134.230(1)(A) requires that CARF accredited programs be paid at 100% of the maximum allowable reimbursement (MAR). The submitted documentation supports that the program is CARF accredited.

Reimbursement is calculated as follows:

- Review of the medical bill finds that the health care provider billed 1 visit for chronic pain management totaling 7 hours at \$125 per hour for a total reimbursement of \$875.00.

2. The total allowable reimbursement for the services in dispute is \$875.00. The insurance carrier paid \$0.00. The amount due to the requestor is \$875.00.

Conclusion

For the reasons stated above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$875.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$875.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

October 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 Rule §133.307.

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 form’s instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.