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 and Address
PRIDE
5701 MAPLE AVENUE, SUITE 100
DALLAS, TX 75235

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-13-0499

Carrier's Austin Representative
Box Number 44

MFDR Date Received
OCTOBER 15, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[Claimant] has a civil court case involving extent of injury, but that matter has no impact on the treatment [Claimant] received at PRIDE. You accepted a lumbar sprain/strain as the compensable injury; PRIDE received preauthorization based on that diagnosis, PRIDE treated using the diagnosis, and PRIDE billed using that diagnosis."

Requestor's Supplemental Position Summary dated October 4, 2012: "Pride obtained pre-authorization on this case on 04/17/12 for Pride 97799 for the Chronic Pain Program for 10 visits 80 hours of the program approved till 6/15/12 and that is what was approved with authorization #9796336 by Coventry utilization department. We then obtained additional auth for more services til 8/17/12 with auth# 9816340. None of the services have been paid for this case all of the documentation has been attached. Per the explanation of benefits from Coventry it indicates they have denied the claims based on extent of injury. We do not understand that denial, since we are treating the patient for the compensable injury of lumbar sprain strain only."

Amount in Dispute: $23,862.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…a claimant is entitled to reasonable and necessary medical care. He is not entitled to care unrelated to the compensable injury. SOAH Docket No. 454-08-3847.M5. A carrier that preauthorizes treatment without limitation may not be able to challenge medical necessity at a later date but it does not waive the right to challenge the relatedness of the treatment to the compensable injury. Extent of injury is an appropriate ground on which to dispute treatment. 28 Tex. Admin. Code §133.240(e). It may be raised even after preauthorization is granted. SOAH Docket No. 454-09-5024.M4."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2012 April 27, 2012	CPT Code 99205	$316.23	$0.00
April 4, 2012	CPT Code 97750-FC (X16)	$672.00	$0.00
April 11, 2012	CPT Code 99214-59	$165.60	$0.00
April 11, 2012	CPT Code 99215-59	$222.31	$0.00
April 23, 2012 through June 12, 2012	CPT Code 97799-CP-CA (X160)	$19,900.00	$6,625.00
June 13, 2012 through June 14, 2012	CPT Code 99455 and 99214	$648.05	$0.00
June 13, 2012	CPT Code 97750-FC(X12)	$504.00	$0.00
September 13, 2012	CPT Code 99214	$165.60	$0.00
September 20, 2012	CPT Code 99215	$222.31	$0.00
May 11, 2012	CPT Code 64494-50 and 64493-50	$730.35	$0.00
TOTAL		$23,862.68	$6,625.00

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 §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
5. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization
   - 219 – Based on extent on injury

Issues

1. Are the respondent's denial reasons for reimbursement of chronic pain management program supported? Is the disputed chronic pain management program eligible for review by Medical Fee Dispute Resolution? Is the requestor entitled to reimbursement for the chronic pain management program?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity and extent of injury? Are the disputed services eligible for review by Medical Fee Dispute Resolution?
3. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?

Findings

1. The requestor billed the respondent for 160 hours of chronic pain management, CPT code 97799-CP-CA rendered from April 23, 2012 through June 12, 2012. The respondent denied reimbursement for these services based upon reason codes "216," "38" and "219". In addition, the Division finds that neither party to the dispute submitted an explanation of benefits for dates of service April 23, April 25, April 27, June 4, June 6, June 7 and June 8, 2012. The Division reviewed the submitted information and finds the following:

   Medical Necessity Issue:

   - Per the explanation of benefits, the chronic pain management program rendered on June 11, June 12, June 13, June 14, 2012 was denied payment based upon reason code "216".
   - The requestor wrote in the position summary that "Pride obtained pre-authorization on this case on 04/17/12 for Pride 97799 for the Chronic Pain Program for 10 visits 80 hours of the program approved till 6/15/12 and that is what was approved with authorization #9796336 by Coventry utilization department. We then obtained additional auth for more services til 8/17/12 with auth# 9816340."
   - 28 Texas Administrative Code §134.600(p)(10) requires preauthorization for "chronic pain management/interdisciplinary pain rehabilitation." On April 17, 2012, the requestor obtained preauthorization approval for Functional Restoration Program, 80 hours, code 97799.
   - 28 Texas Administrative Code §134.600(q)(5) states, "The health care requiring concurrent review for an extension for previously approved services includes: (5) chronic pain management/interdisciplinary pain rehabilitation." On May 21, 2012, the requestor obtained preauthorization for an additional 80 hours of Functional Restoration Program, code 97799.
   - 28 Texas Administrative Code §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care)." Furthermore, 28 Texas Administrative Code §134.600(l) states, "The carrier shall not withdraw a preauthorization or concurrent review approval once issued."

   The Division finds that because preauthorization was obtained for the disputed 160 hours of chronic pain management services a medical necessity issue does not exist; therefore, the respondent's denial based upon reason code "216" is not supported.

   Extent of Injury Issue:

   - Based upon the submitted explanation of benefits, the respondent denied reimbursement for the chronic pain management program rendered on April 30, May 2, May 4, May 7, May 8, May 10, May 18, May 22, May 29, May 30, May 31, June 1, June 11, and June 12 with reason code "219."
   - 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim.
   - The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent-of-injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   The Division finds that due to the unresolved extent-of-injury issues, the medical fee dispute on above listed dates of service are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.307.

   Dismissal provisions: 28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

   No Explanation of Benefits:

- Neither party to the dispute submitted an explanation of benefits for denial of payment of chronic pain management rendered on dates of service April 23, April 25, April 27, June 4, June 6, June 7 and June 8, 2012; therefore, the disputed services will be reviewed per the Division's fee guideline.
- 28 Texas Administrative Code §134.204(h)(1)(A) states "(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 MAR." The requestor appended modifier "CA" to code 97799 to designate that it was a CARF accredited program.
- 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 a total of 53 hours on April 23, April 25, April 27, June 4, June 6, June 7 and June 8, 2012. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x 53 hours = $6,625.00. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $6,625.00. This amount is recommended for reimbursement.

2. The submitted explanation of benefits, indicate that there are **unresolved** issues of medical necessity and extent-of injury for the following services:

Dates of Service	Disputed Services	EOB Denial Reason Code
April 3, 2012 April 27, 2012	CPT Code 99205	219
April 4, 2012	CPT Code 97750-FC (X16)	219
April 11, 2012	CPT Code 99214-59	219
April 11, 2012	CPT Code 99215-59	219
May 11, 2012	CPT Code 64494-50 and 64493-50	219
June 13, 2012	CPT Code 97750-FC (X12)	219, 216
June 13, 2012 through June 14, 2012	CPT Code 99455 and 99214	219, 216

Resolution of a Medical Necessity Dispute. The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

Notice of Dispute Sequence. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent of injury issue are attached.

The division finds that due to the unresolved medical necessity and CEL issues, the medical fee dispute for above listed services are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.307.

Dismissal provisions: 28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

3. Based upon the submitted documentation, the Division finds that neither party to the dispute submitted bills or explanation of benefits for code 99214 rendered on September 13, 2012 and code 99215 rendered on September 20, 2012.

   28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250" Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB" Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(K).

   The Division concludes that this dispute for code 99214 rendered on September 13, 2012 and code 99215 rendered on September 20, 2012was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

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 $6,625.00.

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 $6,625.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		10/13/15
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 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.