Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TX HEALTH DBA INJURY 1
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
ARCH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0857-01

MFDR Date Received
DECEMBER 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 97799 CPCA was preauthorized, # [redacted] & # [redacted] therefore it is deemed medically necessary."

Amount in Dispute: $19,406.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2012 July 20, 2012 July 23, 2012 July 24, 2012 July 25, 2012 July 26, 2012 July 27, 2012 August 7, 2012 August 8, 2012 August 14, 2012 August 20, 2012 August 22, 2012	Chronic Pain Management Program – CPT Code 97799-CP-CA (These services contain compensability, extent, and/or liability issues)	$11,562.50	$00.00
July 13, 2012 July 16, 2012 July 17, 2012 August 10, 2012 August 13, 2012 August 15, 2012 August 16, 2012 August 21, 2012	Chronic Pain Management Program – CPT Code 97799-CP-CA	$7,843.75	$7,843.75

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 a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for the disputed services.
4. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 Texas Register 626, sets the reimbursement guidelines for the disputed service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 219-Based on extent of injury.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - Billing unrelated to Workers' Compensation diagnosis.

Issues

1. Have the relevant extent of injury issues been resolved for dates of service July 19, 2012, July 20, 2012, July 23, 2012, July 24, 2012, July 25, 2012, July 26, 2012, July 27, 2012, August 7, 2012, August 8, 2012, August 14, 2012, August 20, 2012 and August 22, 2012?
2. Does a medical necessity issue exist for dates of service July 13, 2012, July 16, 2012, July 17, 2012, August 10, 2012, August 13, 2012, August 15, 2012, August 16, 2012 and August 21, 2012?
3. Is the requestor entitled to reimbursement for dates of service July 13, 2012, July 16, 2012, July 17, 2012, August 10, 2012, August 13, 2012, August 15, 2012, August 16, 2012 and August 21, 2012?

Findings

1. The respondent denied reimbursement for the disputed chronic pain management program rendered on July 19, 2012, July 20, 2012, July 23, 2012, July 24, 2012, July 25, 2012, July 26, 2012, July 27, 2012, August 7, 2012, August 8, 2012, August 14, 2012, August 20, 2012 and August 22, 2012 based upon reason code "219."

   28 Texas Administrative Code §133.305(a)(5) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury."

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or 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 Division reviewed the submitted documentation and finds the following:

   - On July 3, 2012 a Benefit Review Conference was held to mediate a resolution of the disputed issues; however, the parties were unable to reach an agreement.
   - On July 9 and 31, 2012 the requestor seeks and obtains preauthorization for a total of160 hours of outpatient chronic pain management.
   - On December 4, 2012, the requestor submits a request for medical fee dispute resolution.
   - On January 17, 2013, a Contested Case Hearing was held.
   - On January 28, 2013, the Contested Case Hearing Officer noted in the BACKGROUND INFORMATION that "There is no expert medical evidence to support those [redacted] should be part of the

compensable injury which would overcome the Designated Doctor. Claimant was diagnosed by a social worker for purposes of determining if she was a candidate for a chronic pain management program. Dr. Vu, as a chiropractor, is not qualified to offer an opinion on these diagnoses. Claimant did not meet her burden of proof regarding these diagnoses."

The Hearing Officer's decision found that "The compensable injury of [redacted] extends to and includes [redacted]. The compensable injury of [redacted], does not extend to and include [redacted]. Claimant had disability resulting from an injury sustained on [redacted] from October 02, 2011, through March 30, 2012. Claimant reached maximum medical improvement on October 02, 2011. Claimant's impairment rating is 0%."

Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.

The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. As a result, reimbursement cannot be recommended.

2. According to the explanation of benefits, the respondent denied reimbursement for dates of service July 13, 2012, July 16, 2012, July 17, 2012, August 10, 2012, August 13, 2012, August 15, 2012, August 16, 2012 and August 21, 2012 based upon denial code "50."

   The requestor states in the position summary that "CPT code 97799 CPCA was preauthorized, #[redacted] & #[redacted] therefore it is deemed medically necessary." In support of their position, the requestor submitted copies of preauthorization reports dated July 9, 2012 and July 31, 2012, that indicate that the respondent's representative, Forte, gave preauthorization approval for a total of 160 hours of chronic pain management program.

   28 Texas Administrative Code §134.600(h) states "Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury." The Division finds that the issue of medical necessity was resolved because the respondent reviewed the request for preauthorization solely based upon medical necessity.

   28 Texas Administrative Code §134.600(l) states, "The insurance carrier shall not withdraw a preauthorization or concurrent review approval once issued." Because preauthorization was obtained, the respondent is prohibited from withdrawing the preauthorization and raising the issue of medical necessity. The Division finds that a medical necessity issue does not exist in this dispute.

3. 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."

   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 62.75 hours for disputed dates of service July 13, 2012, July 16, 2012, July 17, 2012, August 10, 2012, August 13, 2012, August 15, 2012, August 16, 2012 and August 21, 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 62.75 hours = $7,843.75. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $7,843.75. This amount is recommended for reimbursement

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 $7,843.75 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		03/07/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN 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.