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
PHYSICIAN MGMT SVCS DBA INJRY 1 TRTMT CTR
5931 DESCO DRIVE
DALLAS TX 75225

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-2171

MFDR Date Received
April 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims are incorrectly denied. The EOB's state the claims were denied due to a peer review. Please note the treatment was preauthorized, per 133.301 (a) convey that the carrier is liable for all reasonable and necessary medical costs when preauthorization is obtained."

Amount in Dispute: $2,016.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this particular case, [injured employee] [redacted] date of injury was initially denied by the carrier. A PLN-1 was filed with the Division of Workers' Compensation on January 4, 0211. This dispute was maintained until June of 1022 when a DWC-24 was entered between the parties accepting an injury that was limited to a right wrist/hand strain/sprain. On April 26, 2012, the carrier obtained a peer review from Dr. Mickey Cho who indicated that a right wrist strain/strain would resolve within six to eight weeks of conservation treatment including therapy and medication. Any treatment beyond January 29, 20112 would not be reasonable or necessary or related to the compensable injury. Dr. Cho is a board-certified orthopedic and hand surgeon. The carrier has subsequently filed a PLN-aa disputing that the compensable injury of [redacted] extends beyond April 26, 2012, which is the date of Dr. Cho's peer review. The carrier's actual position is that the compensable injury of [redacted] does not extend beyond the date of January 29, 2011..."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2012	CPT Code 90801	$229.63	$0.00

June 19, 2012, June 27, 2012, July 5, 2012 and August 17, 2012	CPT Code 90806	$542.44	$529.59
July 6, 2012	CPT Code 96101	$369.39	$369.39
August 28, 2012	CPT Code 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 §133.305 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 sets out the preauthorization guidelines.
5. 28 Texas Administrative Code §134.203 sets out the guidelines for professional services.
6. 28 Texas Administrative Code §134.204 sets out the guidelines for Division specific services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization.
   - W1 – Workers' compensation jurisdictional fee schedule adjustment.
   - 18 – Duplicate claim/service.
   - W4 – Workers' Compensation Medical Treatment Guideline Adjustment.

Issues

1. Did the Respondents position summary contain information that indicates there is an unresolved extent of injury?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
3. Are the insurance carrier's reasons for denial or reduction of payment supported and is the requestor entitled to reimbursement?

Findings

1. The respondents' position summary raises extent of injury stating that a PLN-1 was filed with the Division on January 4, 2011. In accordance with 28 Texas Administrative Code §133.307(d)(2)(F) 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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section. Therefore services for dates of service June 19, 2012 through August 28, 2012 will be reviewed.

2. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for CPT Code 90801, date of service May 21, 2012. Review of the EOB presented by the requestor indicate denial reason code "216 – Based on the findings of a review organization." Review of the preauthorization recommendations submitted by the requestor finds that the requestor did not obtain preauthorization for this date of service.

   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.

3. The insurance carrier denied CPT Code 90806, dates of service June 19, 2012 through August 17, 2012 (four (4) dates of service) with claim adjustment reason codes "216 – Based on the finds of a review organization", "W1 - Workers' compensation jurisdictional fee schedule adjustment","W4 – Workers' Compensation Medical Treatment Guideline Adjustment" and "18 – Duplicate claim/service." In accordance with 28 Texas Administrative Code § 134.600(c) The insurance 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." Review of the submitted information finds that the requestor obtained preauthorization for this service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines. Review of the documentation supports reimbursement in accordance with 28 Texas Administrative Code §134.203(c)(1). Reimbursement is recommended in the amount of $529.59. (54.86 ÷ 34.0376) x $84.15 x 2 dates of service = $271.26 and (54.86 ÷ 34.0376) x 80.14 x 2 dates of service = $258.33.

   The insurance carrier denied CPT Code 96101 for date of service July 6, 2012 with claim adjustment reason code "216 – Based on the finds of a review organization." In accordance with 28 Texas Administrative Code § 134.600(c) The insurance 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." Review of the submitted information finds that the requestor obtained preauthorization for this service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines. Review of the documentation supports reimbursement in accordance with 28 Texas Administrative Code §134.203(c)(1). Reimbursement is recommended in the amount of $369.39. (54.86 ÷ 34.0376) x $79.83 x 3 units.

   The insurance carrier denied CPT Code 99799-CP-CA for date of service August 28, 2012 with claim adjustment reason codes "216 – Based on the finds of a review organization and "W4 – Workers' Compensation Medical Treatment Guideline Adjustment." In accordance with 28 Texas Administrative Code § 134.600(c) The insurance 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." Review of the submitted information finds that the requestor obtained preauthorization for this service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines. Review of the documentation supports reimbursement in accordance with 28 Texas Administrative Code §134.204 (h)(5) 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. Review of the documentation supports reimbursement at $125 per hour. Therefore, reimbursement in the amount of $875.00 is recommended.

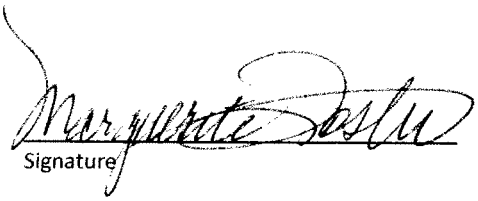
Conclusion

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 $1,773.98.

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 $1,773.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature



Signature

Marguerite Foster
Medical Fee Dispute Resolution Officer

September 24, 2015
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, 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 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 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.