



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

Chronic Pain Recovery Center

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-14-0418-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were paid at a rate which is significantly below the Division of Worker's Compensation's prescribed fee schedule."

Amount in Dispute: \$3,243.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money."

Response Submitted by: ESIS South Central WC Claims, PO Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3 through July 9, 2013	97799-CP-CA	\$18,937.50	\$18,937.50

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 provides medical fee guideline for workers' compensation specific services.
- 28 Texas Administrative Code §134,600 sets out guidelines for prospective and concurrent review of health care
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 216 – Based on the findings of a review organization
 - W9 – Unnecessary treatment with peer review

Issues

1. Did the requestor support denial based on peer review?

2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied as, W9 – “Unnecessary treatment with peer review.” Review of the submitted documentation finds;
 - a. April 19, 2013, Dr. James Herbertson states in pertinent part, “...the patient does have a chronic pain syndrome.”
 - b. May 15, 2013, ESIS Utilization review certifies the following: 80 hours of chronic pain management program between 5/10/2013 and 7/9/2013
 - c. June 24, 2013, ESIS Utilization review certified the following: 80 hour of chronic pain management program between 6/19/2013 and August 18, 2013.

Therefore, the carrier’s denial is not supported.

2. 28 Texas Administrative Code §134.600 (p) states, “Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation;” Submitted documentation supports the services in dispute were prior authorized and will therefore be reviewed per applicable rules and fee guidelines.

28 Texas Administrative Code §134.204(h)(1)(A) states, “The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (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) 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 calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
June 3, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 5, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 6, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 7, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 10, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 11, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 12, 2013	97799-CP-CA	\$1600.00	8	\$125 x 8 = \$1000.00	0.00	\$1,000.00
June 13, 2013	97799-CP-CA	\$1500.00	7.5	\$125 x 7.5 = \$937.50	0.00	\$937.50
June 14, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
June 24, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
June 25, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
June 26, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
June 27, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
June 28, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
July 1, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
July 2, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
July 3, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
July 8, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
July 9, 2013	97799-CP-CA	\$1600.00	8	125 x 8 = \$1000.00	0.00	\$1,000.00
	Total	\$30,300.00		\$18,937.50	\$0.00	\$18,937.50

3. The Division finds provisions of Rule 134.600 have been met. The total MAR for the pre-authorized services is \$18,937.50. This amount 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 \$18,937.50.

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 \$18,937.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August , 2014
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.