



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

HEALTHTRUST LLC

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-14-0769-01

Carrier's Austin Representative

Number 19

MFDR Date Received

NOVEMBER 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Each time these dates of service were denied as having no preauthorization or exceeding the preauthorization granted. The last two reviews were based upon reconsideration request that was submitted to the carrier along with copies of the preauthorization letters granted by URA. HealthTrust felt that they did not have access to the computer software from Genex UR department. Both times these claims were "processed as denied per adjuster instructions: disallowed services beyond certification for this episode/stay, per required medical exams. Attached you will find the preauthorization letters establishing the time period for these procedures to be provided. You will see that the services were provided within the allowable time frame set forth by URA."

Amount in Dispute: \$22,223.84

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: "The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 13, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 4, 2012	90806	\$147.56	\$0
January 16, 2013	96151	\$236.28	\$0
January 16, 2013 through March 8, 2013	97799-CP	\$21,840.00	\$11,200.00
Total		\$22,223.84	\$11,200.00

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 §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
3. Explanation of benefits were reduced/denied by the respondent with the following reason codes:
 - 197- Precertification/authorization/notification absent.
 - W4- Workers' compensation medical treatment guideline adjustment. \$0.00.
 - 193- Precertification/authorization/notification absent. \$0.00.
 - 18- Duplicate claim/service. This change effective 1/1/2013; Exact duplicate claim/service (Use only the Group Code QA).

Issues

1. Did the requestor waive the right to medical fee dispute resolution for service date September 4, 2012?
2. Did the requestor obtain preauthorization for CPT Code 96151 for service date January 16, 2013?
3. What is the reimbursement guideline for CPT Code 97799-CP?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute is September 4, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 4, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
2. Per 28 Texas Administrative Code §134.600 (p)Non-emergency health care requiring preauthorization includes:...(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier..."

Review of the Office of Disability Guidelines (ODG) does not list CPT Code 96151. Therefore, the services for CPT Code 96151 require preauthorization Per 28 Texas Administrative Code §134.600. Review of the documentation submitted by the requestor does not find that preauthorization was obtained for the said services. For the reasons stated above, reimbursement for CPT Code 96151, service date January 16, 2013 is not recommended.

3. Per 28 Texas Administrative Code §134.204 "(h)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. (1)Accreditation by the CARF is recommended, but not required. (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. (B)If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

Review of the CMS-1500s and the medical documentation finds that the requestor billed for the following;

The requestor billed 8 hours of 97799-CP on January 16, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on January 22, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on January 23, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on January 25, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on January 28, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 4, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 8, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 11, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 19, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 22, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on February 25, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on March 5, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on March 6, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

The requestor billed 8 hours of 97799-CP on March 8, 2013 and documented 8 hours. Reimbursement is calculated at \$100.00/hour at 8 hours. The recommended amount is therefore \$800.00.

As a result the requestor is entitled to a total recommended amount of \$11,200.00 for service dates January 16, 2013 through March 8, 2013.

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 \$11,200.00.

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 \$11,200.00 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

July 21 , 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.