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 and Address

BODIES IN BALANCE
SUITE 210
4151 SOUTHWEST FREEWAY
HOUSTON TX 77027

Respondent Name
GENERAL INSURANCE CO OF AMERICA

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-14-1145-01

MFDR Date Received
December 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauth # [redacted]

Amount in Dispute: $10,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response to the DWC060 request. A copy of the DWC060 was placed in the insurance carrier representative box on December 30, 2013. As a result, the division will issue a findings and decision based on the documentation contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2013 through March 6, 2013	Chronic pain management	$10,000.00	$5,300.00

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 §134.203 sets out the fee guideline procedures for professional medical services.
3. 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

Issues

1. Did the requestor obtain preauthorization for the disputed chronic pain management services?
2. What rules apply to determine the reimbursement for a non-CARF accredited chronic pain management program?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   The requestor submitted a copy of preauthorization letter (reference number [redacted] dated February 18, 2013 authorizing a chronic pain management program 8 hours/day 5xwkx2wks; start date 02/13/13; end date 04/13/13.

   Per 28 Texas Administrative Code §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.

   The requestor disputes non-payment of the chronic pain management services rendered on February 21, 2013 through March 6, 2013, within the preauthorized time frame indicated in the preauthorization reference number: [redacted] As a result, the disputed services will be reviewed pursuant to 28 Texas Administrative Code §134.203.

2. Per 28 Texas Administrative Code §134.204 (h)(1)(B) "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. (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."

   Per 28 Texas Administrative Code §134.204 (h) (5) (A-B) "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 submitted documentation finds that the requestor billed CPT code 97799-CP and did not appended modifier –CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement is calculated per 28 Texas Administrative Code §134.204 (h) for dates of service February 21, 2013 through March 6, 2013. Reimbursement for non-CARF accredited programs is calculated at 80% of the MAR for each date of service.

3. To determine reimbursement for a chronic pain management program, the division applies the following:

   28 Texas Administrative Code §134.204 (h) (1) (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.

   28Texas Administrative Code §134.204 (h) (5) (A) (B) "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 CMS-1500s finds that the requestor billed for 8 hours of CPT code 97799-CP rendered on February 21, 2013 through March 6, 2013. Review of the medical documentation finds that:

   Date of service February 21, 2013, the requestor documented 4:45 hours and is therefore entitled to reimbursement in the amount of $475.00.

Date of service February 22, 2013, the requestor documented 6 hours and is therefore entitled to reimbursement in the amount of $600.00.

Date of service February 25, 2013, the requestor documented 5:45 hours and is therefore entitled to reimbursement in the amount of $575.00.

Date of service February 26, 2013, the requestor documented 5:20 hours and is therefore entitled to reimbursement in the amount of $525.00.

Date of service February 27, 2013, the requestor documented 5:45 hours and is therefore entitled to reimbursement in the amount of $575.00.

Date of service February 28, 2013, the requestor documented 5:45 hours and is therefore entitled to reimbursement in the amount of $575.00.

Date of service March 1, 2013, the requestor documented 3:30 hours and is therefore entitled to reimbursement in the amount of $350.00.

Date of service March 4, 2013, the requestor documented 5:15 hours and is therefore to entitled reimbursement in the amount of $525.00.

Date of service March 5, 2013, the requestor documented 6:15 hours and is therefore entitled to reimbursement in the amount of $625.00.

Date of service March 6, 2013, the requestor documented 4:45 hours and is therefore entitled to reimbursement in the amount of $475.00.

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 $5,300.00.

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 $5,300.00 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	January 17, 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).