



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Pain and Recovery Clinic

**Respondent Name**

Indemnity Insurance Company of North America

**MFDR Tracking Number**

M4-15-0075-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

September 8, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Our facility has been having difficulties with the above carrier in processing these authorized services...After filing a reconsideration and still being denied as 'these services have already been considered for reimbursement', it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized."

**Amount in Dispute:** \$7812.50

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Carrier hereby files this, its response to the healthcare provider's request for medical fee dispute resolution and would show the division as follows:

1. The healthcare provider, Pain Recovery Clinic, has requested additional reimbursement for services rendered between September 3, 2013 and December 19, 2013;
2. While the services rendered were pre-authorized, the fee amount charged for those services was not agreed to in advance or authorized by the utilization review agent (dated 08/23/13);
3. The services made the subject of this medical fee dispute concern chronic pain management;
4. The Carrier has not disputed payment for the services pre-authorized but has disputed the amount of reimbursement the provider is entitled to under the medical fee guidelines. Each of the attached EOBs state that the fees sought by the healthcare provider exceed the fee schedule established by the state. As such, each of the bills for services rendered between September 3, 2013 and December 19, 2013 were reduced based on a state fee schedule adjustment;
5. Further, the reimbursement amount paid by the Carrier to the healthcare provider was further adjusted due to a bundling or unbundling of services as set forth in the explanation of benefits. "

**Response Submitted by:** Smith & Carr, P.C., 9235 Katy Freeway, Ste. 200, Houston, TX 77024

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3 – December 19, 2013	Chronic Pain Management	\$7812.50	\$5375.00

## **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 medical fee disputes.
2. 28 Texas Administrative Code §134.204 (h) sets out the fee schedule guidelines for chronic pain management.
3. 28 Texas Administrative Code §134.600 sets out the pre-authorization guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - From Explanations of Benefits dated 9/18/13-9/25/13 for dates of service 9/3/13-9/17/13:
    - W1 – Workers Compensation State Fee Schedule Adjustment
    - 309 – The charge for this procedure exceeds the fee schedule allowance.
    - OA – The amount adjusted is due to bundling or unbundling of services.
  - From Explanations of Benefits dated 2/23/14 for dates of service 9/3/13-9/17/13:
    - B13 – This code was not explained.
    - 247 – A payment or denial has already been recommended for this service.
    - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not “reasonable or necessary”. The amount adjusted is generally not the patient’s responsibility, unless the workers’ compensation state law allows the patient to be billed.
  - From Explanation of Benefits dated 1/23/14 for date of service 12/19/13:
    - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
    - 247 – A payment or denial has already been recommended for this service.
    - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patient’s responsibility, unless the workers compensation state law allows the patient to be billed.

### **Issues**

1. What is the correct MAR amount for the requested services?
2. Were the requested services billed correctly?
3. Were the requested services medically necessary according to 28 Texas Administrative Code §134.600?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

1. Dates of service 9/3/13-9/17/13 were denied due to the Workers' Compensation fee schedule. Per 28 Texas Administrative Code §134.204 (h), “The following shall be applied to...Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs...(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 MAR...**(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.**”

A review of the submitted documentation indicates that the requested services were performed by a non-CARF accredited program. Therefore, the correct MAR amount for the requested services is \$100.00 per hour. These services are not subject to bundling.
2. Dates of service 9/3/13-9/17/13 and 12/19/13 were denied stating, “These are adjustments initiated by the payer, for such reasons as billing errors...” A review of the submitted documentation indicates that the chronic pain management services were billed using CPT Code 97799 with modifier CP. According to 28 Texas Administrative Code §134.204 (h)(5)(A), this is billed correctly. Therefore, the denial of billing errors is not supported.
3. Dates of service 9/3/13-9/17/13 and 12/19/13 were denied stating, “These are adjustments initiated by the payer, for such reasons as... services that are considered not reasonable or necessary.” Submitted

documentation supports that there is a pre-authorization approved for chronic pain management for dates of service 8/21/13-11/20/13. 28 Texas Administrative Code §134.600 (h) states, "...the insurance carrier shall either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury..."

Further, 28 Texas Administrative Code §134.600 (l) states, "The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued."

Therefore, dates of service 9/3/13-9/17/13 are considered medically necessary.

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

A review of the documentation submitted does not find that date of service 12/19/13 was pre-authorized. Therefore, this date of service is not considered medically necessary according to 28 Texas Administrative Code §134.600.

4. A review of the submitted reports finds the following:

- Date of service 9/3/13 – 4 hours (units) of chronic pain management were documented. The correct reimbursement for 4 units is \$400.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$375.00 is recommended.
- Date of service 9/4/13 – 6 hours (units) of chronic pain management were documented. The correct reimbursement for 6 units is \$600.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$575.00 is recommended.
- Date of service 9/5/13 - 6 hours (units) of chronic pain management were documented. The correct reimbursement for 6 units is \$600.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$575.00 is recommended.
- Date of service 9/6/13 - 6 hours (units) of chronic pain management were documented. The correct reimbursement for 6 units is \$600.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$575.00 is recommended.
- Date of service 9/10/13 – 6.5 hours (units) of chronic pain management were documented. The correct reimbursement for 6.5 units is \$650.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$625.00 is recommended.
- Date of service 9/11/13 – 6.5 hours (units) of chronic pain management were documented. The correct reimbursement for 6.5 units is \$650.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$625.00 is recommended.
- Date of service 9/12/13 - 6 hours (units) of chronic pain management were documented. The correct reimbursement for 6 units is \$600.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$575.00 is recommended.
- Date of service 9/13/13 – 5.25 hours (units) of chronic pain management were documented. The correct reimbursement for 5.25 units is \$525.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$500.00 is recommended.
- Date of service 9/16/13 – 4.5 hours (units) of chronic pain management were documented. The correct reimbursement for 4.5 units is \$450.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$425.00 is recommended.
- Date of service 9/17/13 – 5.5 hours (units) of chronic pain management were documented. The correct reimbursement for 5.5 units is \$550.00. The insurance carrier paid \$25.00. Therefore, additional reimbursement of \$525.00 is recommended.
- No reimbursement is recommended for date of service 12/19/13.

**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 \$5375.00.

**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 \$5375.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

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Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

January 6, 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, 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.**