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
PRC HEALTH SERVICES

Respondent Name
INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-15-1052-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bills were submitted for reconsideration and were denied due to FINDINGS OF A REVIEW ORGANIZATION. We received preauthorization for all dates of service that were approved for medical necessity by Bunch Care Solutions."

Amount in Dispute: $4,862.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...preauthorization is given in this claim was for ICD-9 Code 338.4, not for 847.0, which the requestors billed the procedures. Because the treatment issues was for a disputed condition or syndrome and not for the condition billed, the requestor's MDR request should be denied."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2013 through December 30, 2013	97799-CP x 6 dates of service	$4,862.50	$3,175.00

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 §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for Medical Fee Guideline for Workers' Compensation Specific Services.
5. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation state fee schedule adjustment.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 247 – A payment or denial has already been recommended for this service

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 203 – Peer review has determined – payment for treatment has not been recommended due to lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.
- 216 – Based on the findings of a review organization.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307 for date of service December 19, 2013?
2. Is the disputed service rendered on December 19, 2013 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor obtain preauthorization for the non-CARF accredited chronic pain management program rendered on December 27, 2013 and December 30, 2013?
4. Did the insurance carrier issue payment according to the medical fee guidelines for dates of service December 16, 2013, December 17, 2013 and December 18, 2013?
5. Is the requestor entitled to reimbursement?

Findings

1. The medical fee dispute referenced above contains unresolved issues of extent-of-injury for date of service December 19, 2013. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

2. The Division hereby notifies the requestor that date of service December 19, 2013 is dismissed, and that the appropriate process to resolve the issue(s) of extent-of-injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

3. The requestor seeks reimbursement for a non-CARF accredited chronic pain management services rendered on December 27, 2013 and December 30, 2013. Review of the EOBs submitted with the DWC 060 document that the insurance carrier denied the disputed services rendered on December 27, 2013 and December 30, 2013 with denial reason codes "203 – Peer review has determined – payment for treatment has not been recommended due to lack of medical necessity. Peer review has provided its findings to the provider in prior documentation and 216 – Based on the findings of a review organization." The Division finds the following:

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

   28 Texas Administrative Code §134.600 states in pertinent part, "(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section... The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

   (1) name of the injured employee;
   (2) specific health care listed in subsection (p) or (q) of this section;
   (3) number of specific health care treatments and the specific period of time requested to complete the treatments;
   (4) information to substantiate the medical necessity of the health care requested;
   (5) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the insurance carrier;

(6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;
(7) name, professional license number or national provider identifier of the health care provider who will render the health care if different than paragraph (6) of this subsection and if known;
(8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and
(9) estimated date of proposed health care."

28 Texas Administrative Code §134.600 states in pertinent part, "(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..." The Division finds that the insurance preauthorized the disputed services therefore; the requestor is entitled to reimbursement pursuant to 28 Texas Administrative Code 134.204 (h).

Review of the preauthorization letter issued by Bunch Care Solutions an ISG Company, dated December 6, 2013 supports that a day program was certified on December 4, 2013 through March 31, 2014. The preauthorization letter did not contain a limit of the certified day program, as a result the disputed services rendered on December 27, 2013 and December 30, 2013 were preauthorized by the insurance carrier's representative and therefore the requestor is entitled to reimbursement in accordance with 28 Texas Administrative Code §134.204.

4. The requestor seeks reimbursement for dates of service December 16, 2013, December 17, 2013 and December 18, 2013. Review of the EOBs submitted by the requestor document that the insurance carrier issued payment in the amount of $25.00 for each date of service for a total reimbursement of $75.00. The insurance carrier denied/reduced the remaining charges with reduction code "W1 – Workers compensation state fee schedule adjustment and 309 – The charge for this procedure/exceeds the fee schedule allowance." The Division finds that the requestor is entitled to additional reimbursement in accordance with 28 Texas Administrative Code §134.204 (h).

   28 Texas Administrative Code §134.204 (h) 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."

   28 Texas Administrative Code §134.204 (h) (1) states, "(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."

   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."

   Review of the CMS-1500 documents that the requestor billed for CPT Code 97799-CP, no –CA modifier was appended to identify the services were CARF accredited, as a result the requestor is entitled to the 80 percent of the hourly reimbursement.

   Review of the submitted documentation for dates of service December 16, 2013, December 17, 2013 and December 18, 2013 December 27, 2013 and December 30, 2013 finds the following:

   Date of service: December 16, 2013, the requestor documented 6 hours and 45 minutes. The MAR reimbursement is $100/hour x 6 hours and 45 minutes = $675.00. The requestor is entitled to $675.00 minus the $25.00 previously paid by the insurance carrier leaves a recommended reimbursement amount of $650.00. As a result, the requestor is entitled to an additional reimbursement in the amount of $650.00.

Date of service: December 17, 2013, the requestor documented 6 hours and 45 minutes. The MAR reimbursement is $100/hour x 6 hours and 45 minutes = $675.00. The requestor is entitled to $675.00 minus the $25.00 previously paid by the insurance carrier leaves a recommended reimbursement amount of $650.00. As a result, the requestor is entitled to an additional reimbursement in the amount of $650.00.

Date of service: December 18, 2013, the requestor documented 6 hours and 15 minutes. The MAR reimbursement is $100/hour x 6 hours and 15 minutes = $625.00. The requestor is entitled to $625.00 minus the $25.00 previously paid by the insurance carrier leaves a recommended reimbursement amount of $600.00. As a result, the requestor is entitled to an additional reimbursement in the amount of $600.00.

Date of Service: December 27, 2013, the requestor documented 6 hours and 30 minutes. The MAR reimbursement is $100/hour x 6 hours and 30 minutes = $650.00. Therefore, the requestor is entitled to $650.00 for this date of service.

Date of Service: December 30, 2013, the requestor documented 6 hours and 15 minutes. The MAR reimbursement is $100/hour x 6 hours and 15 minutes = $625.00. Therefore, the requestor is entitled to $625.00 for this date of service.

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 $3,175.00.

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 $3,175.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		November 5, 2015
Signature	Medical Fee Dispute Resolution Officer	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.