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
Pain & Recovery North

Respondent Name
Employers Preferred Ins Co

MFDR Tracking Number
M4-15-1777-01

Carrier's Austin Representative
Box 04

MFDR Date Received
February 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The facility recognizes that the compensable diagnosis extends to shoulder sprain strain (840,9), however the same diagnoses was used in the pre-authorization, treatment protocol AND our HCFAs which has an indicator on compensable diagnoses 840.9."

Amount in Dispute: $14,937.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider did request for authorization for the services rendered through Unimed, utilization review company, and it was approved. However, the request indicates the diagnosis is pain disorder associated with both psychological factors and a general medical condition, and major depression moderate. These diagnoses are not related per the Designated Doctor or the CCH Decision and Order on file."

Response submitted by: EIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2014 through August 25, 2014	97799 CP	$14,937.50	$14,937.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 sets out the reimbursement guidelines for specific workers

compensation services
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 - Pre-certification or authorization or notification absent
   - 167 - This (these) diagnosis (es) is (are) not covered

Issues

1. Were the services in dispute prior authorized?
2. Is the insurance carrier's position supported?
3. What rule is applicable to reimbursement?
4. Is additional reimbursement due?

Findings

1. The requestor is seeking reimbursement for chronic pain management services submitted as Code 97799 - CP. The insurance carrier denied all dates of service as 197 - Pre-certification or authorization or notification absent." Review of the submitted documentation found,

   - Unimed Direct approval of CPT:97799 from June 12, 2014 to July 8, 2014 under UMD ID: 1590031.

   - Unimed Direct approved of CPT:97799 from July 23, 2014 to September 8, 2014 under UMD ID: 1619704.

   The span dates of the approval cover the dates of service in question.

   The carrier's denial for lack of pre-auth is not supported and will not be considered in this review.

   The second denial of 167 - This (these) diagnosis(es) is (are) not covered.

   28 TAC 134.600 (l)(3) states in pertinent parts,

   > The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approve shall include:
   >
   > > (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury

   DWC found no notice was given to the health care provider regarding the extent or relatedness. This denial is not supported and will not be considered in this review.

2. The respondent states, "...the request indicates the diagnosis is pain disorder associated with both psychological factors and a general medical condition, and major depression moderate. These diagnoses are not related per the Designated Doctor or the CCH Decision and Order of File."

   28 TAC 133.307 (d)(2)(F) states in pertinent parts,

   > Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   >
   > > (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and record
   > >
   > > > (F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party.

Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

DWC finds the insurance carrier position of "These diagnoses are not related per the Designated Doctor or the CCH Decision and Order of File" is a new issue. This position will not be considered. The services in dispute will be reviewed per applicable fee guidelines.

3. The applicable fee guideline is found in 28 TAC 134.204 (h)(5)(A) and (B) which states,

(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.

The maximum allowable reimbursement based on the above is;

Date of service in dispute	Submitted Code	Authorization number	Units	Allowed amount
June 16, 2014	97799 CP	1590031	6.5	$812.50
June 17, 2014	97799 CP	1590031	7	$875.00
June 19, 2014	97799 CP	1590031	6.5	$812.50
June 20, 2014	97799 CP	1590031	7	$875.00
July 2, 2014	97799 CP	1590031	6.5	$812.50
July 3, 2014	97799 CP	1590031	6.5	$812.50
July 7, 2014	97799 CP	1590031	7	$875.00
July 8, 2014	97799 CP	1590031	6.5	$812.50
July 28, 20014	97799 CP	1619704	6.5	$812.50
July 29, 2014	97799 CP	1619704	6.5	$812.50
July 31, 2014	97799 CP	1619704	6.5	$812.50
August 1, 2014	97799 CP	1619704	6.5	$812.50
August 4, 2014	97799 CP	1619704	7	$875.00
August 5, 2014	97799 CP	1619704	7	$875.00
August 18, 2014	97799 CP	1619704	6	$750.00
August 21,2014	97799 CP	1619704	7	$875.00
August 22, 2014	97799 CP	1619704	6.5	$812.50

August 25, 2014	97799 CP	1619704	6.5	$812.50
			Total	$14,937.50

4. The total allowable reimbursement is $14,937.50. 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 $14,937.50.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $14,937.50, 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	May 21, 2019

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. 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.