



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

Ultimate Pain Solutions

Respondent Name

Commerce and Industry Insurance

MFDR Tracking Number

M4-15-2925-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the corrected procedures were for CPT Codes 97545 and 97546."

Amount in Dispute: \$6400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "From the information provided by the requestor, the carrier could not determine what treatment was done for compensable conditions and what was done for non-compensable conditions..."

The carrier asks that you find Ultimate Pain Solutions is not due a reimbursement as it can not be determined what, if any, treatment was for the compensable condition."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 12 - October 21, 2014, Work Conditioning Program, \$6400.00, \$864.00

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 guidelines for billing and reimbursing Division-specific services.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §133.210 explains the medical documentation required for a medical bill.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- B12 – Services not documented in patients’ medical records.
 - VF04 – The medical records attached do not match the CPT code billed.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - Workers Compensation State Fee Schedule Adjustment.
 - CPT code submitted is based on service time. This charge cannot be processed until we obtain the length of time spent on this procedure code.
 - The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
 - Payment is 80 percent of the MAR for a CARF-accredited program. Documentation of CARF-accreditation for the program must be provided.
 - Payment adjusted because the payer deems the information does not support this many/frequency of services.
 - The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider’s charge was granted an allowance up to the MUE value.
 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
 - A primary procedure has not been billed and/or recommended for payment. A charge for an add-on procedure cannot be paid.

Issues

1. Did the insurance carrier raise a new issue?
2. Are the insurance carrier’s reasons for denial or reduction of payment supported?
3. What is the reimbursement amount for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. In their position statement, the insurance carrier argues that “it cannot be determined what, if any, treatment was for the compensable condition.” 28 Texas Administrative Code §133.240(e) and (h) address actions that the insurance carrier is required to take during the medical billing process when the insurance carrier determines that the medical service was not related to the compensable injury. These provisions, in pertinent part, are specified as:
 - (e) ... The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:
 - (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and
 - (2) the injured employee when payment is denied because: ...
 - (C) the health care was unrelated to the compensable injury, in accordance with §124.2 of this title ...
 - (h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: ...
 - (3) the condition for which the health care was provided was not related to the compensable injury.

In addition, 28 Texas Administrative Code §133.307 (d) states, in relevant part,

- (2) ...Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent...

(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..."

Review of the submitted documentation finds that a new issue was introduced which had not been properly raised on the explanations of benefits, so the Division will only address the issue(s) raised during the bill review process.

2. The insurance carrier denied disputed services with claim adjustment reason codes "B12 – Services not documented in patients' medical records," "VF04 – The medical records attached do not match the CPT code billed," and "CPT code submitted is based on service time. This charge cannot be processed until we obtain the length of time spent on this procedure code." 28 Texas Administrative Code §134.204 (h)(2)(A) states, in relevant part, "The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier 'WC.' Each additional hour shall be billed using CPT Code 97546 with modifier 'WC.'..." In addition, 28 Texas Administrative Code §133.210 (c)(3) defines the requirements for documentation of return to work rehabilitation programs.

Review of the submitted documentation finds that the dispute involves CPT Codes 97545-WC and 97546-WC for dates of service September 12, 15, 22, 26, and October 3, 6, 8, 13, 17, and 21, 2014. Documentation for each date of service indicates three hours of work conditioning was performed. The submitted documentation meets the requirements of 28 Texas Administrative Code §133.210 (c).

28 Texas Administrative Code §133.240 (d) further provides that "The insurance carrier may request additional documentation, in accordance with §133.210 of this title (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges." Submitted documentation does not indicate that the insurance carrier requested additional documentation in accordance with 28 Texas Administrative Code §133.210. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.204 (h)(2)(B) states, in relevant part, "Reimbursement shall be \$36 per hour..." Each date of service in dispute included three hours of work conditioning. Therefore, the Maximum Allowable Reimbursement (MAR) for the disputed services is \$108.00 per day.

Further, 28 Texas Administrative Code §134.204 (h)(1)(B) states, in relevant part, "The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." The requestor did not indicate CARF accreditation. Therefore, the reimbursement amount for the disputed services is \$86.40 per date of service, for a total of \$864.00.

4. The total allowable for the disputed services is \$864.00. The insurance carrier paid \$0.00. Therefore, reimbursement of \$864.00 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 \$864.00.

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 \$864.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	July 22, 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, 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 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.