



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

Monzer H. Yazji, M.D. and Associates

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-15-3815-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

July 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medical Fee Guidelines allows a fee reimbursement of \$800.00 for each procedure code a total of \$1,600.00. You have paid \$1,000.00, owing us \$600.00."

Amount in Dispute: \$600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the documentation submitted to substantiate the performance of Chronic Pain Management by Dr. Yazji, the Office finds that the requested 3 hours per date of service is not substantiated by way of the injured worker attending and/or performing a medical treatment service. The documentation supports the injured worker watching video's regarding individual nutritional choices and specific nutritional diet plans and preparing nutritional drinks. There is no substantiated evidence submitted to show that these videos are approved methods of treatment of chronic pain by the AMA or the ODG Guidelines."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22 & 26, 2015	Chronic Pain Management Program	\$600.00	\$600.00

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information which is needed for adjudication.
 - 295 – Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - P12 – Workers’ Compensation jurisdictional fee schedule adjustment.
 - W3 – Additional payment made on appeal/reconsideration.
 - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier initially denied disputed services with claim adjustment reason codes 16 – “CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION,” and 295 – “SERVICE CANNOT BE REVIEWED WITHOUT REPORT OR INVOICE...” Subsequently, the insurance carrier made a reduced payment on the disputed service with claim adjustment reason codes 1001 – “BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.” The insurance carrier further explained this reduction in their position statement that the provider did not substantiate that videos documented as part of the treatment “are approved methods of treatment of chronic pain by the AMA or the ODG Guidelines.”

28 Texas Administrative Code §134.204 (h) states, in relevant part,

...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.

For this reason, the disputed services are not required to meet the approved methods of treatment of chronic pain by the AMA or the ODG Guidelines. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The MAR for the disputed services is subject to the fee guidelines found in 28 Texas Administrative Code §134.204 (h)(5), which 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.

Further, 28 Texas Administrative Code §134.204 (h)(1)(B) states, “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.” The disputed services involve CPT Code 97799-CP for 8 hours on dates of service January 22 and 26, 2015. Modifier “CA” was not included. Therefore the MAR for each date of service is \$800.00.

3. The total MAR for the disputed services is \$1600.00. The insurance carrier paid \$1000.00. An additional reimbursement of \$600.00 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 \$600.00.

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 \$600.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>September 4, 2015</u>
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, 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.