



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 AND RECOVERY CLINIC

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-15-4201-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. The services were AUTHORIZED by the precertification department of Broadspire upon peer review and are not subject to retrospective review which clearly violates Texas Labor Code 134.600. We feel that our facility should be paid according to the CARE fee schedule guidelines."

Amount in Dispute: \$5,187.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The treatment made the basis of this dispute was not medically necessary for the injuries in dispute. I refer you to the report of the designated doctor, Dr. Scott Harrell, D.C., He states that there was no ODG recommended treatment performed after this date (February 4, 2014) for the accepted diagnosis."

Response Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2015 through May 18, 2015	97799-CP-CA x 6	\$5,187.50	\$5,062.45

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 requires preauthorization for non-emergency health care.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - D51 – Unnecessary treatment based on peer review
 - V – Unnecessary treatment (w/peer review)

Issues

- Did the insurance carrier issue preauthorization for the disputed chronic pain management services?
- Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CARF accredited chronic pain management services rendered on April 24, 2015 through May 18, 2015. Review of the EOBs submitted with the DWC 060, document that the insurance carrier denied the disputed services with denial reason codes “D51 – Unnecessary treatment based on peer review and V – Unnecessary treatment (w/peer review).” Peer review has determined – payment for treatment has not been recommended due to lack of medical necessity. 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 Broadspire A Crawford Company, dated April 22, 2015 finds the following:

Treatment Requested	Chronic Pain Management Program 80 hours for the [injury], as an outpatient
Determination	Recommended prospective request for 1 Chronic Pain Management Program 80 hours for the [injury], as an outpatient between 4/16/2015 and 5/31/2015 be certified

The Division finds that the disputed CARF accredited chronic pain management services rendered between April 24, 2015 through May 18, 2015 were preauthorized by the insurance carrier. As a result, the requestor is entitled to reimbursement in accordance with 28 Texas Administrative Code §134.204.

2. 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, and –CA modifier to identify that the services are CARF accredited. As a result, the requestor is entitled to the 100 percent of the hourly reimbursement.

Review of the submitted documentation for dates of service April 24, 2015 through May 18, 2015 finds the following:

Date of service: April 24, 2015, the requestor billed for 7 hours and documented 7 hours. The MAR reimbursement is \$125/hour x 7 hours = \$875.00. Therefore, the requestor is entitled to \$875.00.

Date of service: April 27, 2015, the requestor billed for 7 hours and documented 6 hours and 45 minutes. The MAR reimbursement is \$125/hour x 6 hours and 45 minutes = \$843.75. Therefore, the requestor is entitled to reimbursement in the amount of \$843.75.

Date of service: May 6, 2015, the requestor billed for 7 hours and documented 6 hours and 45 minutes. The MAR reimbursement is \$125/hour x 6 hours and 45 minutes = \$843.75. Therefore, the requestor is entitled to reimbursement in the amount of \$843.75.

Date of Service: May 7, 2015, the requestor billed for 7 hours and documented 6 hours and 45 minutes. The MAR reimbursement is \$125/hour x 6 hours and 45 minutes = \$843.75. Therefore, the requestor is entitled to reimbursement in the amount of \$843.75.

Date of Service: May 11, 2015, the requestor billed for 7 hours and documented 7 hours. The MAR reimbursement is \$125/hour x 7 hours = \$875.00. Therefore, the requestor is entitled to \$875.00.

Date of Service: May 18, 2015, the requestor billed for 6.5 hours and documented 6 hours and 15 minutes. The MAR reimbursement is \$125/hour x 6 hours and 15 minutes = \$781.20. Therefore, the requestor is entitled to \$781.20 for this date of service.

The Division finds that the requestor is entitled to reimbursement in the amount of \$5,062.45 for disputed dates of service April 24, 2015 through May 18, 2015 for preauthorized CPT Code 97799-CP-CA.

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 \$5,062.45.

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 \$5,062.45 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

November 12, 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.