Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FUNCTIONAL PAIN CENTER

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-16-0494-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
OCTOBER 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Four separate preauthorization requests were submitted to [Claimant's] insurance agency (SORM/IMO), and each subsequently approved by SORM/IMO. Approval documentation provided by SORM/IMO indicated services to be provided for the ICD-9 code 840.6, despite our requests to render services to the lumbar region. All provided documentation indicates services were provided to the lumbar region, and all billing was conducted under the provided code of 840.9. It is without a doubt that the insurance agency was aware of the error of coding; however, continued to approve services and allow our agency to bill incorrectly, based on an ICD-9 code provided by them and the treating physician. Knowing that services are being provided to the correct body area, and to allow services to continue being rendered, but with awareness of a faulty billing code, could be interpreted as stealing by the insurance agency."

Amount in Dispute: $27,715.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Research of the claim found a PLN-11 dated 3/27/2015 followed up with a CCH decision issued on 10/21/2015 where the hearing officer determined that the injury did not extend to Supraspinatus Sprain/Strain. The Requestor's billing reflects that treatment was being performed for ICD 9-840.6-Sprain supraspinatus which has been adjudicated as not compensable. Furthermore, the Office respectfully requests the Division deem the disputed charges for dates of service 9/22/2014 through 10/26/14 are not eligible for review as the Office found that dates of service are not filed within the time frame set forth by the Division to file a medical dispute pursuant to Rule 133.307(c)(1)(A)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2014	CPT Code 96150 (X12)	$540.00	$0.00
October 6, 2014 through November 21, 2014	CPT Code 97799 (X8) (22 Dates)	$1,200.00/ea	$2,000.00
October 15, 2014 December 4, 2014	CPT Code 90899 (X2)	$1,200.00/ea	$0.00
TOTAL		$27,715.00	$2,000.00

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
3. 28 Texas Administrative Code §141.1 sets out the procedure for resolving extent of injury disputes.
4. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 11-The diagnosis is inconsistent with the procedure.
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - 199-Number of services exceed utilization agreement.
   - 282-This charge does not appear to be related to the injury and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.
   - 15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - W3-Additional payment made on appeal/reconsideration.
   - 293-This procedure requires prior authorization and none was identified.
   - 947-Upheld no additional allowance has been recommended.
   - 1241-No additional reimbursement allowed after review of appeal/reconsideration/request for second review.
   - 1003-In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 131-Claim specific negotiated discount.
   - 272-Service reviewed per client instructions.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 272-Service reviewed per client instructions.

Issue

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Extent of Injury?
2. Does a timely filing issue exist in this dispute?
3. Is the requestor entitled to reimbursement for chronic pain management program rendered on October 30 and November 6, 2014?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for services rendered on September 22, October 6, October 7, October 15, October 16, October 21, October 23, October 27, October 28, October 29, October 31, November 4, November 5, November 14, November 21 and December 4, 2015 based upon reason code "282."

   Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   Dispute resolution sequence: 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.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, 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. As a courtesy to the requestor, instructions on how to file for resolution of the extent of injury issue are attached.

The division finds that due to the unresolved extent of injury issues, the medical fee dispute request for dates of service September 22, October 6, October 7, October 15, October 16, October 21, October 23, October 27, October 28, October 29, October 31, November 4, November 5, November 14, November 21 and December 4, 2014 are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §141.1.

Dismissal provisions: 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.

2. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are September 22, 2014 through December 4, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 26, 2015. Review of the submitted documentation finds that the disputed services rendered on October 8, October 9, October 10, October 14, October 20 and October 22, 2014 do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section for these dates; consequently, the requestor has waived the right to medical fee dispute resolution for services rendered on October 8, October 9, October 10, October 14, October 20 and October 22, 2014.
3. Based upon the submitted explanation of benefits, the respondent denied reimbursement for the November 6, 2014 services based upon reason codes "131" and "272." The respondent did not submit any documentation to support a negotiated discount between parties; therefore, the disputed services will be reviewed per the Division's fee guideline.

   Neither party to the dispute submitted a copy of explanation of benefits for the services rendered on October 30, 2014; therefore, the disputed services will be reviewed per the Division's fee guideline.

   28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) 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."

   The Division finds that the requestor billed CPT code 97799-CP-CA for eight (8) hours on the two (2) disputed dates of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x eight (8) hours = $1000.00 per day. $1000.00 times the two disputed dates is $2,000.00. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $2,000.00. This amount is recommended for reimbursement

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this

dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $2,000.00.

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 $2,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

		11/19/2015
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.