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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH, DBA
INJURY 1 OF DALLAS

Respondent Name
STANDARD FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-16-3815-02

Carrier's Austin Representative
Box Number 05

MFDR Date Received
August 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was approved for the Chronic Pain Management Program. . . . PER the attached CCH D&O extends to include L4-5 lumbar disc disorder. . . . CPT code 97799 CPCA was preauthorized.

Amount in Dispute: $20,562.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical treatment at issue consists of a chronic pain program with dates of service March 7, 2016 through June 10, 2016. For multiple reasons, this request should be denied. The claimant's injury is limited to [conditions specified in the contested case hearing officer's decision and order]. The Division determined in a Contested Case Hearing . . . that the injury does not extend to radiculopathy. There is insufficient evidence the treatment at issue was related to the compensable injury."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2016 to June 10, 2016	Chronic Pain Management Program Division specified code: 97799-CPCA	$20,562.50	$10,125.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. 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 §133.305 sets out general provisions regarding medical dispute resolution.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out procedures regarding a benefit review conference.
4. 28 Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.
5. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.

6. 28 Texas Administrative Code §133.250 sets out requirements for reconsideration of payment for medical bills.
7. 28 Texas Administrative Code §134.600 sets out requirements regarding preauthorization of health care.
8. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 219 – BASED ON EXTENT OF INJURY.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
   - 5050 – Claim is denied. No payment will be made.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Are there unresolved issues relating to the extent of injury?
2. May the respondent assert new denial reasons or defenses after the filing of a request for MFDR?
3. Did the health care provider fail to obtain preauthorization for the disputed services?
4. Are there unresolved issues regarding the medical necessity of the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the following disputed dates of service with claim adjustment reason code 219 – "BASED ON EXTENT OF INJURY":

   March 8, 2016; March 11, 2016; March 16, 2016; March 24, 2016; April 25, 2016; April 26, 2016; April 28, 2016; April 29, 2016; May 12, 2016; May 16, 2016; May 18, 2016; May 20, 2016; May 23, 2016; May 25, 2016; May 31, 2016; June 2, 2016; June 3, 2016; June 6, 2016; June 7, 2016; June 9, 2016; June 10, 2016

   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.

   Both parties indicate that a Contested Case Hearing (CCH) had been held to determine the extent of injury, but they remain in contention as to the extent of the injury relating to the services performed on the above dates. Review of the submitted CCH decision finds that it does not reference the disputed dates of service above; therefore, the division concludes that there unresolved issues of extent-of-injury relating to the disputed services performed on the above dates of service. These services are not eligible for medical fee dispute resolution at this time.

   28 Texas Administrative Code §133.307(f)(3)(C) provides that the division may dismiss a request for MFDR if the request contains an unresolved compensability, extent of injury, or liability dispute for the claim. Accordingly, the request for dispute resolution of the above dates of service is hereby dismissed without prejudice. The requestor may request medical fee dispute resolution again at a later date—subject to the requirements of the rules—once all issues of extent of injury, compensability or liability have been resolved.

   The procedures for resolving any outstanding issues of compensability, liability, or extent of injury, are found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   Rule §133.307(f)(3) further provides that a dismissal is not a final decision by the division. The medical fee dispute may be resubmitted for review as a new dispute subject to the requirements of the rules.

   Rule §133.307(c)(1)(B)(i) provides that a request for medical fee dispute resolution may be filed later than one year after the date(s) of service if the request is "filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability."

2. The respondent raises new denial reasons or defenses in their position statement that were not previously presented to the requestor prior to the filing of the request for medical fee dispute resolution.

   Rule § 133.240(a) requires that:

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill . . . **not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill.

   Rule §133.240(e) requires that:

   > The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title . . . 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

   Rule §133.250(g) requires that:

   > The insurance carrier shall take final action on a reconsideration request **within 30 days** [emphasis added] of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:
   > (1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or
   > (2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

   All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request

   Review of the submitted materials finds no explanations of benefits with denial reasons relating to extent of injury or other information to support that the insurance carrier, prior to the filing of the request for medical fee dispute resolution, had raised issues of extent of injury, compensability or liability with respect to service dates:

March 7, 2016;	March 9, 2016;	March 10, 2016;	March 15, 2016;	March 17, 2016;	March 21, 2016;
March 22, 2016;	March 23, 2016;	March 25, 2016;	March 28, 2016;	March 29, 2016;	May 2, 2016;
May 4, 2016;	May 5, 2016;	May 6, 2016;	May 9, 2016;	May 10, 2016	

   Rule §133.307(d)(2)(F) requires that:

   > 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.

   The insurance carrier's failure to assert on the explanations of benefits or otherwise inform the health care provider of the respondent's denial reasons or defenses during the bill review process—before the request for MFDR—constitutes grounds for the division to find a waiver of defenses at Medical Dispute Resolution.

   As no information was presented to support that the insurance carrier had provided to the requestor any denial reasons or defenses relating to the extent of injury, compensability or liability for the above dates of services prior to the filing of the MFDR request, the division finds the respondent has waived such defenses. As there are no outstanding issues regarding compensability, liability, or extent of injury, these services are eligible for MFDR and will therefore be reviewed for payment according to applicable division rules and fee guidelines.

3. The insurance carrier denied payment for disputed services performed March 9, 2016; March 10, 2016; March 15, 2016; March 25, 2016; and March 28, 2016 with claim adjustment reason code:

   197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION."

   The requestor submitted documentation to support that preauthorization was obtained.
   The supporting documentation included:

   - Sedgwick utilization review report authorizing a chronic pain management program—80 hours, medically certified by peer review, from February 5, 2016 through April 8, 2016.
   - Sedgwick utilization review report authorizing additional chronic pain management program (outpatient) — 80 hours, medically certified by physician advisor, from April 15, 2016 through July 15, 2016.

   Based on the submitted documentation, the division finds that the provider obtained preauthorization for the disputed services. The insurance carrier's denials for lack of preauthorization are not supported; therefore, disputed dates of service March 9, 2016; March 10, 2016; March 15, 2016; March 25, 2016; and March 28, 2016 will be reviewed for payment according to applicable division rules and fee guidelines.

4. The insurance carrier denied payment for service date March 22, 2016 with claim adjustment reason code:

   50 – "THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER."

   Rule §133.240(b) requires that:

   > the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments).

   As preauthorization had been obtained prior to rendering the services, the insurance carrier may not deny reimbursement for the disputed health care based on medical necessity. The division finds that the insurance carrier's denial based on medical necessity is inappropriate — the denial reason does not meet the requirements of Rule §133.240(b) and is not supported. Accordingly, this service will be reviewed for reimbursement according to applicable division rules and fee guidelines.

5. This dispute regards chronic pain management services billed under Division of Workers' Compensation specific code 97799-CPCA, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(h)

   Rule §134.204(h)(1)(A) requires that:

   > 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.

   Review of the submitted information finds that the health care provider was CARF accredited.

   Rule §134.204(h) requires that:

   > The following shall be applied for billing and reimbursement of Chronic Pain Management and 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.

Reimbursement is calculated as follows:

- March 7, 2016, 8 hours × $125 = $1,000.00
- March 9, 2016, 8 hours × $125 = $1,000.00
- March 10, 2016, 8 hours × $125 = $1,000.00
- March 15, 2016, 4 hours × $125 = $500.00
- March 17, 2016, 4 hours × $125 = $500.00
- March 21, 2016, 4 hours × $125 = $500.00
- March 22, 2016, 6 hours × $125 = $750.00
- March 23, 2016, 4.5 hours × $125 = $562.50
- March 25, 2016, 5 hours × $125 = $625.00
- March 28, 2016, 5 hours × $125 = $625.00
- March 29, 2016, 5 hours × $125 = $625.00
- May 2, 2016, 4 hours × $125 = $500.00
- May 4, 2016, 3.5 hours × $125 = $437.50
- May 5, 2016, 2 hours × $125 = $250.00
- May 6, 2016, 3 hours × $125 = $375.00
- May 9, 2016, 4.5 hours × $125 = $562.50
- May 10, 2016, 2.5 hours × $125 = $312.50

The total reimbursement for the above services is $10,125.00.
The insurance carrier has paid $0.00.
The total payment amount recommended is $10,125.00.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the amended findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

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 $10,125.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. Pursuant to a grant of authority by the Commissioner of Workers' Compensation to issue, amend or withdraw medical fee dispute resolution findings, decisions and orders, the respondent is hereby ORDERED to remit to the requestor the amount of $10,125.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	February 24, 2017
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 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.