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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
CHARTER OAK FIRE INSURANCE CO

MFDR Tracking Number
M4-18-0329-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
OCTOBER 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied dates of service 5/1/17 through 5/19/17 due to 'this procedure code was invalid on the date of service' and the billed service' and the billed serviced has no allowance in fee schedule.' Both of these denial reasons are erroneous. The carrier the carrier denied dates of service 5/15/17 through 5/19/17 due to 'preauthorization exceeded' & 'No preauthorization obtained.' This was a non-network claim. Since North Texas Pain Recovery Center's Work Hardening program is CARF accredited by rule (134.600), preauthorization was not required."

Amount in Dispute: $4,608.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As to dates of service 05-01-2017 to 05-05-2017, the Carrier has reviewed the documentation and determined the Provider is entitled to reimbursement for the disputed services. Reimbursement is being issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation. As to dates of service 05-15-2017 to 05-19-2017, the Carrier contends the Provider is not entitled to reimbursement. These dates of service were denied reimbursement on the basis that the services required preauthorization that was not obtained. The Claimant previously underwent 30 sessions of chronic pain management and 20 sessions of functional restoration…As the Provider failed to obtain preauthorization for the work hardening program and the work hardening program exceeded the ODG criteria due to the prior similar rehabilitation programs, the Provider is not entitled to reimbursement."

Position Summary Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2017 thru May 19, 2017	CPT Codes 97545-WH-CA and 97546-WH-CA 9 dates at 8 hours per date to equal 72 Hours of Work Hardening	$4,608.00	$0.00

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, effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305, effective March 30, 2014, sets out the general rules for disputes.
3. 28 Texas Administrative Code §133.308, effective May 31, 2012, sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §134.230, effective July 7, 2016 sets out the reimbursement guidelines for rehabilitation management programs.
5. 28 Texas Administrative Code §134.600, effective March 30, 2014, 9requires preauthorization for specific treatments and services.
6. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 181-Payment adjusted because the procedure code was invalid on the date of service.
   - 107-Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
   - 254-The billed service has no allowance in fee schedule.
   - 033B-This claim is being denied for multiple reasons. A TWCC-62 stating the specific reasons will be sent to you under separate cover.
   - 292-This procedure code is only reimbursed when billed with the appropriate initial base code.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies. Use only if no other code is applicable.
   - W3-Additional payment made on appeal/reconsideration.
   - Z001-For explanation of anon-payment by the adjuster, please contact the adjuster on file.
   - 197-Payment denied/reduced for absence of precertification/authorization.
   - ODG2-Preauthorization exceeded. The preauthorization for the principle service has been exceeded; therefore, the ancillary services are deemed medically unnecessary.
   - ODG3-No preauthorization obtained for principle service; therefore, the ancillary services are reduced based on medical necessity.

Issues

Is the requestor due reimbursement for work hardening program rendered from May 1, 2017 thru May 19, 2017?

Finding

1. The respondent wrote payment would be issued for the work hardening program rendered from May 1, 2017 thru May 5, 2017 based upon the fee guideline; therefore, additional reimbursement is not recommended for these dates.

2. According to the explanation of benefits, the respondent denied reimbursement for the work hardening program rendered from May 15, 2017 thru May 19, 2017 based upon a lack of preauthorization.

   28 Texas Administrative Code §134.600(p)(4) requires preauthorization for: "all work hardening or work conditioning services requested by: (A) non-exempted work hardening or work conditioning programs; or (B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection."

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier."

   The requestor billed CPT codes 97545-WH-CA and 97546-WH-CA for the diagnosis "Strain of muscle, fascia and tendon at neck."

   According to the Neck Chapter of the Official Disability Guidelines (ODG), a work hardening program is a recommended treatment for a neck sprain/strain; therefore, the program did not require preauthorization.

3. The respondent also denied reimbursement for the work hardening program rendered from May 15, 2017 thru May 19, 2017 based upon a lack of medical necessity.

The division addressed this issue in Work Conditioning and Work Hardening, ODG and Preauthorization Process Questions and Answers, June 2014, "Work conditioning and Work Hardening services provided within the ODG guideline criteria but without obtaining preauthorization are subject to retrospective utilization review for medical necessity, and reimbursement may be denied based on lack of medical necessity."

Review of the submitted documentation finds that the medical fee dispute for dates of service May 15, 2017 thru May 19, 2017 contains unresolved issues of medical necessity, and that the insurance carrier notified the requestor of such issues in its explanation of benefits during the medical bill review process.

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under Health Care Providers or their authorized representatives.

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. The Division finds that due to the unresolved medical necessity issues, the medical fee dispute request for dates of service May 15, 2017 thru May 19, 2017 are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

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. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that this dispute for dates of service May 15, 2017 thru May 19, 2017 are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/23/2019 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