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
OAKBEND MEDICAL CENTER

Respondent Name
SAFETY NATIONAL CASUALTY CORP.

MFDR Tracking Number
M4-18-0648-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[the injured employee] was provided with work hardening at the Hospital to treat and ultimately work on improving the dexterity of [the] right shoulder. Prior to the date of service, the Hospital received authorization for work hardening by the adjuster, Ms. Carmen Vega, on November 30, 2016. At that time, the Hospital still had its CARF accreditation. This is reflected in the Hospital's business record attached, on the note entry for November 30, 2016."

Amount in Dispute: $5,580.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the requestor, Oakbend Medical Center has failed to provide evidence demonstrating the service facility in question was CARF accredited as required . . . preauthorization is required for all work hardening and work conditioning rendered by non-exempted programs."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 2, 2017 to January 13, 2017	Outpatient Hospital – Work Hardening Therapy	$5,580.04	$0.00

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 §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.210 sets out the fee guideline for Workers' Compensation specific services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Duplicate claim/service
   - CJ – At least 20% but < 20% impaired/limited/restricted
   - R1 – Duplicate Billing.
   - C1 – At least 1% but < 40% impaired/limited/restricted
   - FC – Functional Capacity Evaluations
   - WH – Work Hardening
   - 197 – Payment adjusted for absence of precert/preauth
   - GO – Service delivered under OP OT care plan
   - R35 – Maximum Units Exceeded, Payment adjusted
   - WH – Work Hardening
   - 246 – This is non-payable code is for required reporting only
   - P13 – Payment reduced/denied based on state WC regs/policies
   - R25 – Procedure billing restricted/see state regulations
   - W3 – Appeal/Reconsideration

Issues

1. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The insurance carrier denied disputed services with denial reason code:

   197 – "Payment adjusted for absence of precert/preauth."

   28 Texas Administrative Code §210(e)(1) requires that modifier "CA" be used when a health care provider bills for a return to work rehabilitation program accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The disputed services were not, however, billed with modifier "CA."

   The provider's position statement asserts, "Prior to the date of service, the Hospital received authorization for work hardening by the adjuster, Ms. Carmen Vega, on November 30, 2016. At that time, the Hospital still had its CARF accreditation."

   The corresponding note states: "DAILY WORK HARDENING AUTHORIZED PER ADJUSTER, CARMEN VEGA, NO PRE-CERT REQUIRED AS WE ARE CARF ACCREDITED."

   No information was presented to support that the services were submitted for utilization review by either party to this dispute. No documentation was presented to support actual preauthorization of the disputed services. The printout of patient notes provided by the requestor supports only that the adjuster advised that authorization was not required so long as the facility was CARF accredited.

   The requestor asserts that the facility *was* CARF accredited as of November 30, 2016. However, the requestor does not assert that the facility was CARF accredited as of January 2017, when the services were rendered. No documentation was provided to support CARF accreditation on the dates of service.

   28 Texas Administrative Code §600(f) requires that "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."

   28 Texas Administrative Code §600(p)(4)(A) requires preauthorization for all work hardening or work conditioning services requested by non-exempted programs.

   As the requestor did not provide any information to support CARF accreditation or that the program was exempt on the dates of service, the division finds that preauthorization was required for the disputed work hardening services. As no information was presented to support utilization review, nor any approval letter or other documentation to support authorization, the division concludes authorization was not obtained. Accordingly, the insurance carrier's denial reasons are supported. Payment cannot be recommended.

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 findings and decision in this dispute are based on the available evidence presented by the requestor and respondent 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 not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 14, 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.