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
INJURY ONE OF DALLAS-FW

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-18-3898-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied per EOB services not documented in patients medical records. CPT code 97799 CPCA was preauthorized, #13495179."

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although we referenced the provider's resubmissions as a 'request for reconsideration', the provider never challenged the carrier's EOB denial language. Each alleged request for reconsideration simply claimed that the services were preauthorized. However, the denial language on the EOB did not involve a preauthorization issue. In other words, the provider never submitted a request for request for reconsideration."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2017	CPT Code 97799-CP-CA (8 hours)	$1,000.00	$1,000.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §133.250 sets out the procedure for medical bill processing and auditing by the insurance carrier.
3. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
4. The services in dispute were reduced or denied payment based upon reason code(s):
    - P12-Workers' compensation jurisdictional fee schedule adjustment.

- B12-Services not documented in patients' medical records.
- W3-Request for reconsideration.

Issues

1. Are the services eligible for review?
2. What is the applicable fee guideline?
3. Is the respondent's denial of payment supported?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent wrote, "Although we referenced the provider's resubmissions as a 'request for reconsideration', the provider never challenged the carrier's EOB denial language. Each alleged request for reconsideration simply claimed that the services were preauthorized. However, the denial language on the EOB did not involve a preauthorization issue. In other words, the provider never submitted a request for request for reconsideration."

   28 Texas Administrative Code §133.307(d)(2)(F) states, "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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." The respondent did not submit documentation to support that the respondent's defense outlined in the position summary was presented to the requestor prior to MFDR.

   The requestor supported compliance with 28 Texas Administrative Code §133.250(d)(1-4) which states, " A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier; (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment."

   The division concludes that services are eligible for review per 28 Texas Administrative Code §133.307.

2. The fee guideline chronic pain management services is found in 28 Texas Administrative Code §134.230.

3. According to the explanation of benefits, the respondent paid $0.00 based upon "B12-Services not documented in patients' medical records," and "P12-Workers' compensation jurisdictional fee schedule adjustment."

   The requestor submitted Chronic Pain Management Program Daily Progress Note dated August 16, 2017 that documents 8 hours of services provided to claimant; therefore, the respondent's denial of payment is not supported.

4. 28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required. (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 maximum allowable reimbursement (MAR). (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."

   The requestor billed 97799-CP-CA; therefore, the disputed program is CARF accredited and reimbursement shall be 100% of the MAR.

   28 Texas Administrative Code §134.230(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.

A review of the submitted medical bill indicates the requestor billed for 8 hours; therefore, 100% of $125.00 = $125 X 8 hours = $1,000.00. The respondent paid $0.00. The requestor is due the difference of $1,000.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,000.00.

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 $1,000.00 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	7/3/2018 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.