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
PAIN & RECOVERY CLINIC OF NORTH HOUSTON

Respondent Name
SOUTHEASTERN FREIGHT LINES, INC.

MFDR Tracking Number
M4-18-5193-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
August 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were AUTHORIZED by Coventry upon peer review and are not subject to retrospective review"

Amount in Dispute: $1,125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 3, 2018 to May 7, 2018	Chronic Pain Management	$1,125.00	$1,125.00

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 §124.2 sets out requirements for carrier reporting and notification.
2. 28 Texas Administrative Code §124.3 sets out rules for investigating an Injury and giving notice of dispute.
3. 28 Texas Administrative Code §133.240 sets out requirements regarding medical payments and denials.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 Texas Administrative Code §134.210 sets out the fee guideline for professional medical services.
6. 28 Texas Administrative Code §134.230 sets out guidelines for Return to Work Rehabilitation services.
7. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
8. 28 Texas Administrative Code §19.2005 provides general standards regarding utilization review.
9. Labor Code 409.021 sets out requirements for disputing compensability and giving notice of refusal to pay.

10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - XG16 – Payment denied based on the findings of a review organization.
    - XG18 – Payment denied based on extent of injury.
    - Z510 – Resolution Manager denial.
    - U301 – This item was previously submitted and reviewed with a notification of decision issued to payor, provider (duplicate invoice).
    - Z362 – REVIEWED: … ORIG CTL Number … ORIG TOTAL RECOMMENDED ALLOWANCE …

Issues

1. Are there any unresolved issues related to extent or liability for the disputed injury?
2. Are there any outstanding issues regarding the medical necessity of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
    - XG18 – Payment denied based on extent of injury.

    Rule §133.240(h) requires the insurance carrier to file notice as required by Labor Code §409.021 and Rules §124.2 and §124.3 if denying payment based on compensability of, liability for, or relatedness to the disputed injury.

    Rule §124.3(e) requires the carrier to file a notice of dispute of extent of injury in accordance with Rule §124.2 (relating to Carrier Reporting and Notification) not later than the earlier of (1) the date the carrier denied the medical bill; or (2) the due date for the carrier to pay or deny the medical bill as provided in Chapter 133.

    Rule §124.2(h) requires the carrier to notify the division and claimant of a dispute of extent of injury using plain language notices prescribed by the division. The notice must describe the action taken and reason(s) for doing so. The statement must contain sufficient claim-specific substantive information for the employee or beneficiary to understand the carrier's position or action. A simple, generic statement using phrases such as "not part of compensable injury," "liability is in question," "under investigation," "eligibility questioned" or similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this rule.

    Furthermore, if a medical fee dispute involves compensability, extent of injury, or liability, Rule §133.307(d)(2)(H) requires carriers to attach to the MFDR response a copy of any related Plain Language Notice issued per Rule §124.2.

    Review of the submitted documentation finds no Plain Language Notices disputing extent of injury in accordance with Rules §133.240(h), §124.3(e) and §124.2(h). Additionally, the insurance carrier failed to maintain any denial reasons related to extent of injury on the EOB issued to the provider after reconsideration of the medical bill.

    The division finds that the insurance carrier's denial reason regarding extent of injury is not supported. The division thus concludes that there are no unresolved issues of compensability, extent of injury, or liability.

2. The insurance carrier denied disputed services with claim adjustment reason code:
    - XG16 – Payment denied based on the findings of a review organization.

    Rule §133.307(d)(2)(I) requires that if the medical fee dispute involves medical necessity issues, the insurance carrier shall attach to the MFDR response a copy of documentation that supports an adverse determination in accordance with 28 Texas Administrative Code §19.2005 (relating to General Standards of Utilization Review).

    The carrier failed to include with their MFDR response a copy of any review organization findings or any documentation to support an adverse determination in accordance with 28 Texas Administrative Code §19.2005.

    Rule §133.240(b) further requires that the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified in accordance with Rule §134.600.

    Moreover, Rule §134.600(l) requires that the insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued.

The submitted documentation shows the health care provider obtained preauthorization for 80 hours of chronic pain management performed between April 13 through July 13, 2018. Thus, regardless of the findings of any review organization, per Rule §134.600(l) the insurance carrier has waived the right to withdraw authorization for the disputed services after having issued preauthorization for them.

Further still, Rule §133.240(b) prohibits the carrier from denying payment based on medical necessity for the health care that was preauthorized.

The insurance carrier's denial reasons related to the findings of a review organization are not supported. The division concludes there are no outstanding issues related to the medical necessity of the disputed services. Consequently, the medical fee issues will be reviewed in accordance with division rules and fee guidelines.

3. This dispute regards chronic pain management services with reimbursement subject to the Medical Fee Guideline for Return to Work Rehabilitation Programs, 28 Texas Administrative Code §134.230(5)(A) requiring the program be billed using code 97799 with modifier "CP." CARF accredited programs shall add "CA" as a second modifier. Per Rule §134.230(5)(B), reimbursement shall be $125 per hour, prorated to the nearest 15-minute increment. Rule §134.230(1)(A) requires that CARF accredited programs be paid at 100% of the maximum allowable reimbursement (MAR). The submitted documentation supports that the program is CARF accredited.

   Reimbursement is calculated as follows:

   - Review of the medical bill finds that the health care provider billed 2 visits for chronic pain management of 4.5 hours each for a total of 9 hours at $125 per hour for a total reimbursement of $1,125.00.

4. The total allowable reimbursement for the services in dispute is $1,125.00. The insurance carrier has paid $0.00. The amount due to the requestor is $1,125.00.

Conclusion

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 $1,125.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,125.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 19, 2018
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.