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 AND RECOVERY CLINIC

MFDR Tracking Number
M4-19-0422-01

MFDR Date Received
September 26, 2018

Respondent Name
CITY OF HOUSTON

Carrier's Austin Representative
Box Number 29

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for CARF certification... After requesting reconsideration in a timely fashion VIA mail to Tristar, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were preauthorized and properly billed."

Amount in Dispute: $384.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The request for recommendation on dates of service 6/1/18 are outside of the Pre-Authorization period of 6/4/18 – 7/4/18. Based on the Pre-Authorization Determination Letter we found the bill was processed correctly."

Response Submitted by: IMO

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 1, 2018	97545-WH-CA and 97546-WH-CA	$384.00	$384.00

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 medical fee disputes.
2. 28 Texas Administrative Code §134.230 sets out the fee guidelines for Return to Work Rehabilitation Programs.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – No explanation provided on the EOB
   - Note: Please provide proof that this facility is in the CARF accredited list

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor submit documentation to support CARF accreditation?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Code(s) 97545-WH-CA and 97546-WH-CA rendered on June 1, 2018. The insurance carrier in the position summary states in pertinent part, "The request for recommendation on dates of service 6/1/18 are outside of the Pre-Authorization period of 6/4/18 – 7/4/18. Based on the Pre-Authorization Determination Letter we found the bill was processed correctly."

   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."

   The respondent submitted a position summary containing a new denial reason. The additional denial reason identified on the position summary states in pertinent part, "The request for recommendation on dates of service 6/1/18 are outside of the Pre-Authorization period of 6/4/18 – 7/4/18. Based on the Pre-Authorization Determination Letter we found the bill was processed correctly," is not a denial reason raised during the medical bill review process, as they are not indicated on the Explanation of Benefits presented with the DWC060 request. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor, or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reason or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

2. The requestor presented two EOBs for consideration in this review, the first EOB is dated August 9, 2018 and contained denial reason codes "W3" and "193," along with the note indicated above. The second EOB is dated September 8, 2018 and contained the denial reasons W3" and "193." The Division finds that the insurance carrier did not submit EOBs to support the preauthorization denial raised in the position summary presented to MFDR. The Division will now review the disputed services and consider the insurance carrier's denial reasons raised during the medical bill review process.

   The insurance carrier requested proof that this facility is in the CARF accredited list. Review of the documentation submitted by the requestor, included a copy of the CARF accreditation letter issued to Pain and Recovery Clinic. The letter, which is dated March 17, 2016 states in pertinent part, "It is my pleasure to inform you that Pain and Recovery Clinic has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following programs(s): Interdisciplinary Pain Rehabilitation Programs -Outpatient (Adults) Occupational Rehabilitation Programs (Adults)."

   The disputed services are Occupational Rehabilitation services, CPT Codes 97545-WH-CA and 97546-WH-CA, dated June 1, 2018 and rendered within the 3-year CARF accreditation period. As a result, the Division finds that the requestor submitted sufficient documentation to support the billing of CPT Code 97545-WH-CA and 97546-WH-CA and the disputed services are therefore subject to review pursuant to 28 Texas Administrative Code §134.230.

3. 28 Texas Administrative Code §134.230 states in pertinent part, "The following shall be applied to Return to Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.

   (1) 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)...

   (3) For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 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..."

Review of the medical bills supports that the requestor billed for one unit of CPT Code 97545-WH-CA for the first two hours of each session. The requestor seeks reimbursement in the amount of $128.00, the MAR for the first two hours is $128.00, as a result, the requestor is entitled to reimbursement in the amount of $128.00.

Review of the medical bills supports that the requestor billed for 4 hours of CPT Code 97546-WH-CA. The requestor seeks reimbursement in the amount of $256.00, the MAR is $256.00, as a result, the requestor is entitled to reimbursement in the amount of $256.00.

4. Review of the submitted documentation finds that the requestor billed for the disputed CPT Codes 97545-WH-CA and 97546-WH-CA, in accordance with 28 Texas Administrative Code §134.230 and is therefore entitled to the sought amount of $384.00 for the work hardening services rendered on June 1, 2018.

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 $384.00.

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 $384.00, 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	November 8, 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.