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
PRC Health Services

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-1865-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per 28 Texas Administrative Code rule 127.10 (h) the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. For medical benefits the insurance carrier shall have 21 days from the receipt of the designated doctor report to reprocess all medical bills previously denied for reasons inconsistent with the findings."

Amount in Dispute: $3,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor attempts to obtain pre-authorization and treatment for non-compensable conditions by making a request and submitting billing using only the compensable injury ICD 10 codes for lumbar sprain/strain. …the Carrier is not required to pay for treatment that is not reasonable, necessary of related to the compensable injury."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6 – 17, 2018	97799 CP	$3,750.00	$3,750.00

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 §134.204 sets out the fee guidelines for workers compensation specific

services.

3. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization
   - 219 – Based on extent of injury
   - P4 – Workers' compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment

Issues

1. Is this dispute subject to dismissal based on extent of injury?
2. Is this dispute subject to dismissal based adverse utilization review?
3. Is the health care provider entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for chronic pain management services rendered from September 6th through 17th, 2018. The insurance carrier denied the services based on the extent of injury.

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability. Review of the submitted documentation finds that the respondent failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on extent to the compensable injury. The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

2. The insurance carrier also indicated the services were denied based on the findings of a review organization.

   The submitted documentation includes Review #5164830 dated September 4, 2018. This report certifies the medical necessity of chronic pain management.

   The insurance carrier's denial is not sufficiently supported. This dispute is not subject to dismissal based on adverse utilization review.

   The services in dispute will be reviewed per applicable Division fee guidelines.

3. The disputes services are subject to 28 TAC 134.204 (h)(5)(B) which states in pertinent part,

   > (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

   Calculation based on the above is as follows:

Date of service	Submitted code	Units	Prior authorization	Maximum allowable reimbursement
September 6, 2018	97799 CP	7	5164830	$125 x 7 = $875.00
September 10, 2018	97799 CP	6.5	5164830	$125 x 6.5 = $812.50
September 11, 2018	97799 CP	5	5164830	$125 x 5 = $625.00
September 12, 2018	97799 CP	6	5164830	$125.00 x 6 = $750.00
September 17, 2018	97799 CP	5.5	5164830	125.00 x 5.5 = $687.50
			Total	$3,750.00

The total allowed amount is $3,750.00. This amount is recommended.

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 $3,750.00.

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 $3,750.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		May 14, 2019
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.