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
NORTH TEXAS REHABILITATION CENTER

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-19-3100-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We had requested 3 authorizations for the 'Brain Injury Program' and were approved for all 3 but, we have yet to be paid for all of the dates of service."

Amount in Dispute: $8,960.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are standing on prior denials for lack of/exceeding preauth."

Response Submitted by: Avidel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 29, 2018 to November 2, 2018	Brain Injury Program	$8,960.00	$8,960.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 267 - [A description of this denial reason code was not found with the submitted materials.]
   - 95 – PLAN PROCEDURES NOT FOLLOWED.
   - U05 – THE BILLED SERVICE EXCEEDS THE UR AMOUNT AUTHORIZED.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 756 – PER RULE 133.25 PROVIDER MAY NOT SUBMIT RECONSIDERATION AFTER THE CARRIER HAS TAKEN FINAL ACTION. SEEK MDR IN ACCORDANCE TO RULE 133.307.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 375 – PLEASE SEE SPECIAL "NOTE" BELOW.
  - PRE-AUTH OBTAINED WAS FOR 40 VISITS THAT STARTED 8/23/18, 8/24/18, 8/27/18, 8/28/18, 8/29/18, 8/30/18, 8/31/18, 9/4/18, 9/5/18, 9/6/18, 9/7/18, 9/11/18, 9/12/18, 9/13/18, 9/14/18, 9/17/18, 9/18/18, 9/19/18, 9/20/18, 9/21/18, 9/24/18, 9/25/18, 9/26/18, 9/27/18, 9/28/18, 10/1/18, 10/2/18, 10/3/18, 10/5/18, 10/8/18, 10/10/18, 10/11/18, 10/12/18, 10/15/18, 10/16/18, 10/17/18, 10/18/18, 10/19/18, 10/22/18, 10/23/18 THIS ENDED THE 40 VISITS AND SHOULD HAVE DENIED 10/24/18, 25, 26TH TOO AS THAT EXCEEDED THE UTILIZATION. 11/6/18 STARTED THE NEXT AUTHORIZED TREATMENT.
- 790 - [A description of this denial reason code was not found with the submitted materials.]
- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
- 901 – LINE REPRICED IN ACCORDANCE WITH A NEGOTIATED RATE.

Issues

1. Did the health care provider exceed the number of certified visits?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code U05 – "THE BILLED SERVICE EXCEEDS THE UR AMOUNT AUTHORIZED." The explanations of benefits contained additional remittance remarks:

   PRE-AUTH OBTAINED WAS FOR 40 VISITS THAT STARTED 8/23/18, 8/24/18, 8/27/18, 8/28/18, 8/29/18, 8/30/18, 8/31/18, 9/4/18, 9/5/18, 9/6/18, 9/7/18, 9/11/18, 9/12/18, 9/13/18, 9/14/18, 9/17/18, 9/18/18, 9/19/18, 9/20/18, 9/21/18, 9/24/18, 9/25/18, 9/26/18, 9/27/18, 9/28/18, 10/1/18, 10/2/18, 10/3/18, 10/5/18, 10/8/18, 10/10/18, 10/11/18, 10/12/18, 10/15/18, 10/16/18, 10/17/18, 10/18/18, 10/19/18, 10/22/18, 10/23/18 THIS ENDED THE 40 VISITS AND SHOULD HAVE DENIED 10/24/18, 25, 26TH TOO AS THAT EXCEEDED THE UTILIZATION. 11/6/18 STARTED THE NEXT AUTHORIZED TREATMENT.

   Rule §134.600(c)(2) provides that the insurance carrier is liable for all reasonable and necessary medical costs relating to health care not listed in subsection (p) "when voluntary certification was requested and payment agreed upon prior to providing the health care" in accordance with subsection (r).

   The disputed services involve a "brain injury program" not listed among the services requiring preauthorization in Rule §134.600(p). The submitted documentation supports the health care provider sought voluntary precertification for the disputed services in accordance with Rule §§ 134.600(c)(2) and (r). The carrier approved 100 visits total, spanning 3 certification requests (approval numbers 1115442, 1240487, 1304035) effective for dates of service from April 10, 2018 through May 5, 2019, with a negotiated payment rate of $2,240.00 per day. The division notes the effective start and end dates partially overlap between the three certification approvals.

   Based on the information presented for review, the carrier paid dates of service August 23, 2018 through September 4, 2018 applying them against the total of 40 visits approved under the second certification, approval number 1240487. The provider, however, asserts those service dates should have been applied against the 40 visits approved under the first certification, approval number 1115442.

   Because the carrier applied those service dates to the second certification (1240487) — before using up the remaining visits from the first certification (1115442) — this caused disputed dates of service October 29, October 31, November 1, and November 2, 2018 to erroneously deny for exceeding the 40 authorized visits approved for the second certification (1240487).

   The provider submitted information to support that no more than the 100 authorized visits were performed in accordance with the effective dates and number of visits approved for each of the three voluntary certifications.

   Based on the preponderance of the evidence, the information submitted by the health care provider was persuasive that voluntary certification was requested and approved for all services. The documentation further supports the number of authorized visits was not exceeded. The insurance carrier, on the other hand, failed to provide documentation to support their position that the provider exceeded the UR amount authorized

   The division thus concludes the insurance carrier's denial reasons are not supported. Consequently, the disputed services will be reviewed for payment in accordance with the Texas Labor Code and division rules.

2. This dispute regards brain injury rehabilitation services for which there is no established division fee guideline. However, documentation supports services were voluntarily pre-certified in accordance with Rule §134.600(c)(2) with payment agreed upon prior to providing the health care.

   The submitted documentation supports a pre-negotiated rate of $2,240 per day. The division notes that for each of the disputed dates of service, the carrier's explanations of benefits indicate a "BILL REVIEW allowance" of $2,240.00 per visit, with payment reduction code 901 – "Line repriced in accordance with a negotiated rate."

   Accordingly, payment is calculated at $2,240.00 per visit for 4 visits, for a total reimbursement of $8,960.00. The insurance carrier paid $0.00. The amount recommended is $8,960.00.

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 emphasizes the findings in this decision are based on the available evidence presented by the requestor and respondent up to the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $8,960.00.

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 reimbursement for the disputed services and hereby ORDERS the respondent to remit to the requestor $8,960.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 12, 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.

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.