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
CHRONIC PAIN RECOVERY CENTER

Respondent Name
CHUBB INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-19-3903-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
April 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was billed and paid correctly in accordance with the administrative rules of the Texas Department of Insurance, Division of Workers' Compensation. [*cf*. 28 TEX. ADMIN. Code 134.204 (h)(5)... Attached please find a copy of the preauthorization with peer review by Lisa Isaac, PhD certifying that the services are within ODG and medically necessary. Ms. Battle indicated that our services were denied based on a peer review opining that no further treatment was indicated. We respectfully request dispute resolution in this matter. "

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response was received.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 21, 2019	97799-CP-CA x 8	$1,000.00	$1,000.00

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 §133.260 sets out the refund guidelines.
3. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
4. 28 Texas Administrative Code §134
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5191 – This amount has been determined to have been paid in excess of the correct allowance. Therefore, an overpayment request is being issued
   - 216 – Based on the findings of a review organization
   - P13 – Payment reduced/denied based on workers' compensation jurisdictional regulations/payment policies

Issue(s)

1. Did the insurance carrier respond to the medical fee dispute?
2. Did the insurance carrier request a refund within the time allowed per 28 Texas Administrative Code §133.260(a)?
3. Did the insurance carrier submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division?
4. Did the requestor respond to the request for a refund from the insurance carrier?
5. Did the insurance carrier meet the requirements of 28 Texas Administrative Code 133.260(d)?
6. Did the requestor remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal prior to the filing of MFDR?
7. Are the insurance carrier's reasons for a refund request supported?
8. Did the insurance carrier support denial reason "5191"?
9. Did the insurance carrier support denial reason "216"?
10. Is the requestor entitled to reimbursement?

Findings

1. The Austin carrier representative for Chubb Indemnity Insurance Company is Downs Stanford, PC. Downs Stanford, PC acknowledged receipt of the copy of this medical fee dispute on May 1, 2019. 28 Texas Administrative Code §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. A decision is therefore based on the information available as authorized under 28 Texas Administrative Code §133.307(d)(1).

2. The requestor seeks resolution of an insurance carrier refund requested for services rendered on January 21, 2019. On February 22, 2019 the carrier requested a refund from the requestor in the amount of $1,000.00 for date of service January 21, 2019.

   28 Texas Administrative Code §133.260(a) states in pertinent part "An insurance carrier shall request a refund with 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided."

   The division finds that the insurance carrier met the requirements of 28 Texas Administrative Code §133.260(a).

3. Per 28 Texas Administrative Code §133.260 (b) "The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division."

   The insurance carrier made the request for a refund on an EOB dated February 22, 2019. The division finds that the insurance carrier met the requirements of 28 Texas Administrative Code §133.260(b) as the carrier made the request on an EOB February 22, 2019.

4. Per 28 Texas Administrative Code §133.260 (c) "A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment."

   The insurance carrier made the request for a refund on February 22, 2019. The requestor responded to the refund request in its March 1, 2019, letter, stating, "The reason 216 based on the findings of a review organization... the services rendered were preauthorized by Sedgwick, Reference # 3154810 on 1/3/19, with peer review by Lisa Isaac, PhD... Sedgwick's utilization review certified these services as being medically necessary. If Sedgwick performed a retrospective peer review, it would be a violation of this TAC guidelines."

   The division finds that the requestor made the appeal on March 1, 2019, within the 45 days as required by Rule §133.260(c)(2).

5. Per 28 Texas Administrative Code §133.260(d) "The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal."

   The insurance carrier acted on the health care provider's appeal on April 3, 2019. The division finds that the insurance carrier met the 45-day timeframe requirements of 28 Texas Administrative Code §133.260(d).

6. Per 28 Texas Administrative Code §133.260(e) "If the insurance carrier denies the appeal, the health provider:
   (1) Shall remit the refund with any applicable interest with 45 days of receipt of notice of denied appeal; **and**
   (2) May request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution – General)."

   Review of the submitted documentation supports that the requestor remitted the refund to the insurance carrier on April 17, 2019 with the 45 days of the receipt of the notice. The requestor submitted sufficient documentation to support that the refund was remitted to the insurance carrier after the denial of the appeal and before the submission of the medical fee dispute. The division finds that the refund dispute request for medical fee dispute resolution was submitted in accordance with 28 Texas Administrative Code 133.260(e). As a result, the Division will review the disputed services and determine if the insurance carrier is entitled to the refund made by the requestor .

7. The requestor seeks reimbursement in the amount of $1,000.00, for CPT Code 97799-CP-CA rendered on January 21, 2019 and previously paid by the insurance carrier. The requestor remitted the refund to the insurance carrier prior to the filing of the medical fee dispute request. The Division will now determine if the requestor is entitled to the monies refunded to the insurance carrier.

   The insurance carrier in its EOB indicated the following reasons for the refund request:

   - 5191 – This amount has been determined to have been paid in excess of the correct allowance. Therefore, an overpayment request is being issued
   - 216 – Based on the findings of a review organization
   - P13 – Payment reduced/denied based on workers' compensation jurisdictional regulations/payment policies

   The Division will address each EOB denial to determine if the insurance carrier was entitled to a refund.

8. Denial reason "5191 – This amount has been determined to have been paid in excess of the correct allowance. Therefore, an overpayment request is being issued."

   To determine the MAR for CPT Code 97799-CP-CA the division applies 28 Texas Administrative Code 134.204 (h) "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 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 MAR."

   28 Texas Administrative Code 134.204(h) (5) "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 unit's 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."

   The requestor billed 8 units of CPT Code 97799-CP-CA at $125/hour for a total of 8 hours amounts to $1,000.00. The insurance carrier paid $1,000.00. The Division finds that the insurance carrier's denial reason is not supported as the fee guideline amount was paid. The Division did not find that the requestor was overpaid or paid in excess of the correct allowance.

9. Denial reason "216 – Based on the findings of a review organization." The requestor submitted a preauthorization letter dated January 3, 2019 issued by Sedgwick to support that the CPT Code 97799-CP-CA (Chronic Pain Management) was preauthorized.

   Section 413.014, titled *PREAUTHORIZATION REQUIREMENTS; CONCURRENT REVIEW AND CERTIFICATION OF HEALTH CARE* (e) states, "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service."

   The Division finds that the insurance carrier's denial reason is not supported.

10. The Division finds that the insurance carrier’s denial reason is not supported as a result, the requestor is entitled to reimbursement in the amount 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 §413.031, the Division has determined that the requestor is entitled to $1,000.00 reimbursement for the disputed services.

Authorized Signature

		August 23, 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 28 Texas Administrative Code §133.307, 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 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.