Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WOL+MED
2436 IH 35 E SOUTH SUITE 336
DENTON TX 76205

Respondent Name
ILLINOIS NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-0053-01

MFDR Date Received
OCTOBER 11, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier responded to our request for reconsideration on the remaining DOS using ANSI code 18, W4, W1, 147. We assert that this is not duplicate billing."

Amount in Dispute: $1,942.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The current dispute involves charges for work hardening from 10/18/06-2/20/07. These bills have either not been received, paid or denied/reduced for the reasons set out on the EOBs. Carrier maintains that it has paid all reasonable, necessary and related charges in accordance with the applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2006	CPT Code 99199-14 Unlisted special service, procedure or report	$100.00	$0.00
November 3, 2006	CPT Code 99199-5 Unlisted special service, procedure or report	$100.00	$0.00
December 18, 2006	HCPCS Code A9150 Non-prescription Drugs	$20.00	$0.00
January 3, 2007 January 31, 2007	CPT Code 99358 Prolonged evaluation and management service before and/or after direct patient care; first hour	$125.00	$0.00
January 26, 2007	CPT Code 97546-WH-CA (x3) Work Hardening Program – CARF Accredited	$192.00	$192.00
January 30, 2007	CPT Code 97546-WH-CA (x5) Work Hardening Program – CARF Accredited	$320.00	$320.00
February 20, 2007	CPT Code 97546-WH-CA (x4) Work Hardening Program – CARF Accredited	$256.00	$256.00
February 28, 2007	CPT Code 97546-WH-CA (x2) Work Hardening Program – CARF Accredited	$128.00	$128.00

March 8, 2007	CPT Code 97545-WH-CA (x2) Work Hardening Program – CARF Accredited	$128.00	$0.00
March 8, 2007	CPT Code 97546-WH-CA (x6) Work Hardening Program – CARF Accredited	$384.00	$0.00
TOTAL		$1,942.00	$896.00

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. Former 28 Texas Administrative Code §133.305, effective January 15, 2007, sets forth general provisions regarding dispute of medical bills.
2. Former 28 Texas Administrative Code §133.307, effective January 15, 2007,sets out the procedures for resolving a medical fee dispute.
3. Former 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific services.
4. Former 28 Texas Administrative Code §134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.
5. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
6. EOBs submitted with the requestor's dispute indicate the respondent has raised issues of Compensability, Extent, and/or Liability for date of service March 8, 2007.
7. EOBs submitted for dates of service October 18, 2006 through February 28, 2007 indicate that the respondent denied reimbursement for the disputed services based upon reason codes:
    - 112-003-The primary provider is a non-contracted provider.
    - 112-Payment adjusted as not furnished directly to the patient and/or not documented.
    - 147-Provider contracted/negotiated rate expired or not on file.
    - 862-002-Pre-authorization is required for reimbursement.
    - 55-Code description not given.
    - 593-Payment for this service is always subsumed or bundled into payment for another service, no separate payment is made.
    - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
    - 18-Duplicate claim/service.
    - 476-$243.00 of the charges are duplicates of bill # 888-H-6909267-0.
    - W1-Workers compensation state fee schedule adjustment.
    - W3-Additional payment made on appeal/reconsideration.
    - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Does a contractual agreement issue exist in this dispute for CPT code 99199 rendered on November 3, 2006?
2. Does a preauthorization issue exist in this dispute for CPT code 99199 rendered on November 3, 2006?
3. Does the documentation support billing CPT code 99199 on November 3, 2006?
4. Is the requestor entitled to reimbursement for CPT code 99199 rendered on October 18, 2006?
5. Is the requestor entitled to reimbursement for HCPCS A9150?
6. Does a contractual agreement issue exist in this dispute for CPT code 99358?
7. Is the value of CPT code 99358 included in the value of another procedure billed on the disputed date?
8. Is the requestor entitled to reimbursement for CPT code 99358?
9. Is the requestor entitled to additional reimbursement for CPT codes 97545-WH-CA and 97546-WH-CA rendered on January 26, 2007, January 30, 2007, February 20, 2007 and February 28, 2007?
10. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code

§133.305 and §133.307 for date of service March 8, 2007?

11. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307 for date of service March 8, 2007?

Findings

1. CPT Code 99199 is defined as "Unlisted special service, procedure or report." According to the submitted medical bills, the requestor billed CPT code 99199 on October 18, 2006 for "add report for pre-authorization"; and on November 3, 2006 for "add peer to peer report". According to the explanation of benefits (EOBs), the respondent denied reimbursement for the report dated November 3, 2006 based upon reason codes "147, 112, 112-003, 862-002." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. The respondent has not supported the above denial/reduction explanations.

2. The respondent also denied CPT code 99199 based upon reason code "862-002." According to 28 Texas Administrative Code §134.600(p), reports are not a service that requires preauthorization; therefore, the respondent's denial reason "862-002" is not supported.

3. According to the explanation of benefits, the respondent also denied reimbursement for CPT code 99199 rendered on November 3, 2006 based upon reason code "112." A review of the submitted documentation finds that the requestor performed peer to peer with Dr. Goldman for preauthorization of twelve sessions of therapy on this date. No documentation was submitted to support billing CPT code 99199; therefore, reimbursement is not recommended.

4. The respondent denied reimbursement for CPT code 99199 rendered on October 8, 2006. Neither party to the dispute submitted an explanation of benefits for the disputed service. Because an EOB was not submitted to support denial of payment, the disputed services will be reviewed for payment in accordance with applicable Division fee guidelines.

   28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   CPT code 99199 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor does not discuss or explain how $100.00 reimbursement for code 99199 is a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

5. The respondent denied reimbursement for HCPCS code A9150-non-prescription drugs rendered on December 18, 2006 based upon reason code "55." A review of the explanation of benefits did not define reason code "55." For this reason, the disputed services will be reviewed for payment in accordance with applicable Division fee guidelines.

   HCPCS Code A9150 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

6. CPT Code 99358 is defined as "Prolonged evaluation and management service before and/or after direct patient care; first hour." According to the Table of Disputed Services, the requestor billed CPT code 99358 on January 3, 2007 and January 31, 2007. The respondent denied reimbursement for CPT code 99358 based upon reason code "147."

   Review of the submitted information found no documentation to support that the disputed services were subject to a contractual agreement between the parties to this dispute. The respondent has not supported the reduction based upon reason code "147."

7. The respondent denied reimbursement for CPT code 99358 rendered on January 31, 2007 based upon reason codes "97 and 593." On the disputed date of service, the requestor billed CPT code 97545-WH and 97546-WH.

   A review of the National Correct Coding Initiatives finds that code 99358 is not global to the work hardening program billed on the disputed date; therefore, the disputed services will be reviewed for payment in accordance with applicable Division fee guidelines.

8. CPT code 99358 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. According to the EOBs, the respondent paid for the disputed work hardening program, CPT codes 97545-WH-CA and 97546-WH-CA, rendered on January 26, 2007, January 30, 2007, February 20, 2007 and February 28, 2007 based upon the fee schedule.

   28 Texas Administrative Code §134.202(e)(5)(A)(i) states "Return To Work Rehabilitation Programs. The following shall be applied 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 commission 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. Section 1 standards regarding Organizational Leadership, Management and Quality apply only to CARF accredited programs.
   (A) Accreditation by the CARF is recommended, but not required.

(i) 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% of the MAR."

28 Texas Administrative Code §134.202(e)(5)(C) states "Work Hardening/Comprehensive Occupational Rehabilitation Programs (for commission purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.)

(i) The first two hours of each session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WH." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $64.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

According to the submitted medical bills, the requestor billed the following: January 26, 2007 = 3 hours; January 30, 2007 = 8 hours; February 20, 2007 = 8 hours; and February 28, 2007 = 8 hours. The total hours billed of work hardening for these disputed dates = 27 hours. The respondent paid for 13 hours; therefore 14 X $64.00 = $896.00. The division finds the requestor is due additional reimbursement of $896.00.

10. The respondent denied reimbursement for the work hardening program, CPT codes 97545-WH-CA and 97546-WH-CA rendered on March 7 and 8, 2007 based upon reason code "W11."

According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.

11. The requestor has failed to support that the disputed services rendered on March 7 and 8, 2007 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for dates of service March 7, 2007 and March 8, 2007. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute for dates of service March 7, 2007 and March 8, 2007. The Division further finds that additional reimbursement in the amount of $896.00 is recommended for the work hardening program rendered on January 26, 2007, January 30, 2007, February 20, 2007 and February 28, 2007 .

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 $896.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		03/07/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.