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

ALTA VISTA HEALTHCARE LP
SUITE 100
1123 NORTH MAIN AVENUE
SAN ANTONIO TX 78212

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-09-1515-01

MFDR Date Received
October 20, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that the sole basis for denial of payment the carrier's denial of the medical necessity of the work hardening program. Their only medical basis for the dispute was a peer review written by Dr. John P. Obermiller (see attached) that was conducted prior to the dates of service in question. Because Alta Vista Healthcare conducts itself in accordance with the high standards of its CARF accreditation, it is exempt from requesting pre-authorization for the work hardening program. Therefore, the denial and review of medical necessity was done via retrospective review and submitted to IRO. In the attached decision, the IRO affirmed that all the dates of service were medically necessary."

Amount in Dispute: $2,281.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The case was reviewed by IRO, with a decision rendered on 10/15/2008. The IRO reversed the denial, finding the services to be medically reasonable and necessary. Carrier will re-audit the billing based upon the IRO decision."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2007 through October 19, 2007	97545-WH-CA and 97546-WH-CA	$986.99	$0.00
October 22, 2007 through December 10, 2007	97545-WH-CA and 97546-WH-CA	$1,294.49	$1,294.49
TOTAL		$2,281.48	$1,294.49

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline).
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W9 – Unnecessary medical treatment based on peer review

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service October 11, 2007 through October 19, 2007?
2. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
3. Did the requestor seek resolution of the medical necessity issues through the IRO process for the services denied/reduced by the insurance carrier for unnecessary medical?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are October 11, 2007 through October 19, 2007. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 20, 2008. This date is later than one year after the date(s) of service in dispute.

   28 Texas Administrative Code §133.307(c)(1)(B)(ii) states; "(c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (B) A request may be filed later than one year after the dates(s) of service if: (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity..."

   Review of the submitted documentation finds that the disputed services involve issues identified in §133.307, subparagraph (B). The IRO decision was issued on July 2, 2008 and the MDR was received in the Medical Dispute Resolution (MDR) section on October 20, 2008. The Division concludes that the requestor has failed to timely file dates of service October 11, 2007 through October 19, 2007 with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service October 11, 2007 through October 19, 2007. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed for dates of service October 11, 2007 through October 19, 2007.

   Review of the submitted documentation finds that dates of service October 22, 2007 through December 10, 2007 were submitted timely and eligible for review. Therefore these disputed dates of service will be reviewed pursuant to 28 Texas Administrative Code §134.202.
2. The requestor indicates on the table of disputed services that the following "Carrier did not pay the MAR. No contract on file, nor provided when requested." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on November 29, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement.

Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. Review of the submitted documentation finds that the insurance carrier denied the disputed work hardening program with denial reason code "W9 – Unnecessary medical treatment based on peer review", the requestor submitted a copy of an IRO decision overturning the insurance carrier's denial of unnecessary medical, as a result, the disputed charges are eligible for review by the medical fee dispute resolution (MFDR) section. The disputed charges dated October 22, 2007 through December 10, 2007 will be reviewed pursuant to 28 Texas Administrative Code §134.202.
4. Per 28 Texas Administrative Code §134.202 "(e) Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (5) 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."

   Per 28 Texas Administrative Code §134.202 (e)(5)(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. (ii) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR."

   Review of the submitted documentation (CMS-1500s) document that the requestor appended modifier "CA" to identify that the disputed work hardening program is CARF accredited, as a result, the hourly reimbursement for a CARF accredited program is 100% of the MAR.

   Per 28 Texas Administrative Code §134.202 (e)(5)(C) "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."

   Review of the submitted documentation finds that the requestor is entitled to additional reimbursement as indicated below:

   The requestor seeks reimbursement in the amount of $11,661.68, minus the insurance carrier payment of $10,367.19, for a total sought amount of $1,294.49. Review of the submitted documentation supports the additional sought amount of $1,294.49 by the requestor. As a result, additional reimbursement is recommended in the amount of $1,294.49.

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 $1,294.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §§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 $1,294.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 16, 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.