

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective September 1, 1993 and Commission Rule 133.305 Titled (Request for Medical Dispute Resolution), a dispute resolution review was conducted by the Medical Review Division regarding a medical payment dispute between the requestor and the respondent named above.

### I. DISPUTE

1. a. Whether there should be reimbursement for work hardening and chronic pain management program.
- b. The request was received on 8-13-02.

### II. EXHIBITS

1. Requestor
  - a. TWCC 60 and Letter Requesting Dispute Resolution
  - b. HCFA-1500s
  - c. EOB
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent
  - a. TWCC 60 and/or Response to a Request for Dispute Resolution
  - b. Redacted EOBs
  - c. Audit summaries/EOB
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Based on Commission Rule 133.305 (h), the Division forwarded a copy of the request to the insurance carrier on 9-6-02. The response from the insurance carrier was received in the Division on 9-19-02. Therefore, the insurance carrier's response is timely.

### III. PARTIES' POSITIONS

1. Requestor:
  - a. **Letter from Vicki Stonum dated 8-12-02**

“Mrs. \_\_\_ received rehabilitation in the work hardening program offered by Work Out. The charges in this claim are based the TWCC fee guidelines. These services should be reimbursed as they were medically necessary and ordered by the Treating Physician. These services were billed correctly according to TWCC 1996 fee guidelines.”

**b. Preauthorization Reports :**

1. 12-19-01 - Preauthorization given for 10 visits at Work Out Work Hardening.
2. 2-5-02 – Preauthorization given for 10 visits of Pain clinic management.

2. Respondent:

- a. TWCC-60 report states in part, “...Cost of reports is included in w/hardening. Chronic Pain Program was paid at Fair and Reasonable Rate.”

**b. Report dated 2-24-03**

“On \_\_\_, \_\_\_ sustained injury to her lower back while lifting a box.

Medical dispute was filed for several services by Work Out Work Hardening for dates from 11/9/01 to 3/19/02. Units were entered wrong for the work hardening of 11/9/01. That has been corrected. A charge of \$50.00 for dos 11/20/01 was denied as the cost of work hardening includes medical reports. Remaining charges for the Chronic Pain program were paid at our fair and reasonable rate.

The Texas Medical Fee Guidelines list procedure code 97799 as requiring documentation of procedure and provides for reimbursement at a ‘fair and reasonable rate’. Liberty Mutual reimburses these services at a fair and reasonable rate of \$125 per hour for an accredited provider and \$100.00 for a non-CARF accredited facility. According to the fee guidelines, documentation is required for services billed with procedure codes designated as DOP.”

#### **IV. FINDINGS**

1. Based on Commission Rule 133.305(d)(1-2), the only dates of service eligible for review are those commencing on 11-9-01 and extending through 3-19-02.

2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
11-9-01	97546 WH	\$128.00	\$102.40	F	\$64.00 /hr for CARF Accredited \$51.20/hr. for Non-CARF Accredited	MFG, Medicine GR (II)(C) and (II)(E)(5)	Based upon the submitted EOBs the provider was reimbursed all other dates based upon Non-CARF rate. The provider did not submit documentation to support that he was a CARF accredited program. Therefore, the provider was correctly reimbursed per MFG and no additional reimbursement is due.
2-11-02 2-12-02 2-13-02 2-14-02 2-15-02 2-18-02 2-19-02 2-25-02 3-4-02 3-5-02 3-6-02 3-7-02 3-11-02 3-12-02 3-14-02 3-19-02 3-19-02	97799 CP 8 units / day	\$1400.00 each date X 17 = \$23,800.0 0	\$800.00 / day X 16 = \$12,800.0 0	M	DOP	Section 413.011(b)  Medicine GR (II)(G)(9)	The provider did not submit any supporting documentation that amount billed was fair and reasonable and that amount paid of \$100.00/hr did not comply with Section 413.011(b).  Based upon the TWCC-60 table, the provider requested dispute resolution for date of service 3-19-02 twice. It appears that this is a typographical error, since the EOBs indicate that only 1 – 3-19-02 was reimbursed.  No additional reimbursement is recommended.
<b>Totals</b>		\$23,928.0 0	\$12,902.4 0				The Requestor <b>is not</b> entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 27<sup>th</sup> day of May 2003.

Elizabeth Pickle  
Medical Dispute Resolution Officer  
Medical Review Division

EP/ep