



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

MILLENNIUM CHIROPRACTIC

Respondent Name

GREAT MIDWEST INSURANCE CO

MFDR Tracking Number

M4-14-2014-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Millennium Chiropractic recently submitted a couple of Request for Reconsiderations to the carrier which the carrier has decided to ignore and not produce any EOBs for those dates of service requested, which is a direct violation of Rule §133.250(f).."

Amount in Dispute: \$2,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2013 through September 19, 2013	CPT Code 97799-CP (22 units) Chronic Pain Management	\$2,200.00	\$2,200.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- 28 Texas Administrative Code §134.600 effective July 1, 2012 requires preauthorization for chronic pain management programs.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45-The duration of care rendered to this patient by the medical group is greater than a number of calendar days that would appear reasonable when compared to the duration of care for other patients treated by other providers for the same condition. Please submit information which would justify the medical necessity for the care. The information submitted to date is not sufficient to make determination of medical necessity.
- 47-The number of visits by the medical group for this patient is greater than a number which appears reasonable when compared to the number of visits provided to other patients for the same diagnosis or

condition. Please submit information which justifies the medical necessity for the visits.

Issues

1. Does a medical necessity issue exist?
2. Is the requestor entitled to reimbursement for chronic pain management services?

Findings

1. According to the submitted explanations of benefits, the insurance carrier denied reimbursement for the chronic pain management based upon a lack of medical necessity.

28 Texas Administrative Code §134.600(c) states "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section..."

28 Texas Administrative Code §134.600 (p)(10) requires preauthorization for "chronic pain management/interdisciplinary pain rehabilitation."

On August 12, 2013, the requestor obtained preauthorization approval for 80 units-10 visits, of chronic pain management effective August 13, 2013 and ending October 13, 2013. The disputed dates of service are within the timeframe that was preauthorized. There is no documentation submitted that the requestor exceeded the 80 units-10 visits that were preauthorized.

28 Texas Administrative Code §134.600(l) states "The insurance carrier shall not withdraw a preauthorization or concurrent review approval once issued."

Because preauthorization was granted for 80 units-10 visits of chronic pain management, the respondent's denial based upon medical necessity is not supported; therefore, reimbursement is recommended per Division fee guideline.

2. 28 Texas Administrative Code §134.204(h)(1)(B) states "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 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "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 units 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 Division finds that the requestor billed CPT code 97799-CP for 22 units from September 13, 2013 through September 19, 2013. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (4)(A) and (B), the MAR for a non-CARF accredited program is \$100.00 per hour (\$125.00 X 80%). \$100.00 times the 22 hours billed is \$2,200.00. The respondent paid \$0.00. The difference between the MAR and amount paid is \$2,200.00. This amount is recommended for additional reimbursement.

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 \$2,200.00.

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 \$2,200.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

5/30/2014
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, effective May 31, 2012, *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 MDR 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.