



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

Pain and Recovery Clinic – North

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-3325-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier made a PARTIAL payment of \$250 for 5.5 units of CPM on 7/14/15. They **still owe us \$300** for a total of \$550 after the CARF discount applied to the \$687.50 billed charges."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the 8/18/2014 is owed to the requestor, Pain and Recovery Clinic for the 8/18/2014 date of service as part of the chronic pain/work hardening program."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2014	Chronic Pain Management (97799-CP)	\$300.00	\$300.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 39 – Services denied at the time authorization/pre-certification was requested.
 - MA09 – Non certification determination based on UR outcome.
 - 1 – Workers Compensation State Fee Schedule Adjustment.
 - 2 – Workers' Compensation Medical Treatment Guideline Adjustment.

- 3 – Payment is 80 percent of the MAR for a CARF-accredited program. Documentation of CARF-accreditation for the program must be provided.
- 4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the total reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 39 – "Services denied at the time authorization/pre-certification was requested," and MA09 – "Non certification determination based on UR outcome." Review of the submitted documentation finds that the requestor supported that preauthorization was obtained for the disputed charges on the date of service in question. Furthermore, the insurance carrier acknowledged in their position statement that payment for this date of service is due. The requestor stated that the insurance carrier has subsequently made a partial payment. The Division finds that the insurance carrier has not maintained a denial for lack of preauthorization. Therefore, this denial is not supported.

2. 28 Texas Administrative Code §134.204 (h)(5) 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.

Review of the submitted information finds that the provider documented five hours and forty-five minutes of chronic pain management treatment for date of service August 18, 2014. The requestor is seeking reimbursement for five hours and thirty minutes. Therefore, the maximum allowable reimbursement (MAR) is \$687.50. 28 Texas Administrative Code §134.204 (1) states,

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.
- (B) 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.

Submitted documentation does not support that the service in question was part of a CARF accredited program. Therefore, the total reimbursement for the disputed services is \$550.00.

3. Total reimbursement for the disputed services is \$550.00. The insurance carrier paid \$250.00. An additional reimbursement of \$300.00 is recommended.

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 \$300.00.

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 \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>October 6, 2015</u>
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.