



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

TX HEALTH DBA INJURY-1 DALLAS

Respondent Name

OLD REPUBLIC GENERAL INSURANCE

MFDR Tracking Number

M4-16-1028-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

DECEMBER 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the EOBs (1st & 2nd denials), claims, and documentation. The patient was approved for treatment."

Amount in Dispute: \$562.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2015	CPT Code 97799-CP-CA Chronic Pain Management	\$562.50	\$562.50

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 a medical fee dispute.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 15(150)-Payer deems the information submitted does not support this level of service.

Issues

- Did the requestor's documentation support the billed services?
- Is the requestor entitled to reimbursement?

Findings

- 1. The respondent denied reimbursement for the disputed services based upon reason codes "15(150)-Payer deems the information submitted does not support this level of service."

The May 15, 2015 Chronic Pain Management Daily Progress Note documents "Total Hours: 4.5 hrs," and the Daily Rehabilitation Worksheet supports 255 minutes of services; therefore, the respondent's denial based upon reason code 15(150) is not supported. The Division finds that the requestor supported position that reimbursement is due.

- 2. 28 Texas Administrative Code §134.204(h)(1)(A) states "(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."

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-CA for 4.5 hours on the disputed date of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is \$125.00 per hour x 4.5 hours = \$562.50. The carrier paid \$0.00. Therefore, the difference between the MAR and amount paid is \$562.50. This amount is recommended for 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 \$562.50.

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 \$562.50 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

12/29/2015
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.