



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

PRC HEALTH SERVICES

Respondent Name

FEDERAL INSURANCE CO

MFDR Tracking Number

M4-16-1967-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

MARCH 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After requesting reconsideration in a timely fashion VIA mail to Gallagher Bassett, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: \$1,937.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has been reimbursement for the services properly billed and performed. No additional reimbursement is owed."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2015 September 4, 2015 October 15, 2015 October 16, 2015	CPT Code 97799-CP X 19.5 hours Chronic Pain Management Program	\$1,937.50	\$0.00

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 a medical fee dispute.
- 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B12-Services not documented in patients' medical records.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

- Z710-The charge for this procedure exceeds the fee schedule allowance.
- BL-CV Reconsideration – Additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. An additional allowance is recommended.
- W3-Request for reconsideration.
- 18-Duplicate claim/service.
- Z362—Reviewed- 11/09/2015 ...total recommended allowance \$1,000.00.
- Z362—Reviewed- 11/09/2015 ...total recommended allowance \$500.00

Issues

Is the requestor entitled to additional reimbursement for chronic pain management program?

Findings

The requestor billed CPT code 97799-CP for a non-CARF accredited chronic pain management program.

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 19.5 units. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is \$100.00 per hour (\$125.00 X 80%). \$100.00 times the 19.5 hours billed is \$1,950.00. The respondent paid \$2,000.00. The Division finds the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/07/2016 Date
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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.