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 CENTER

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-16-2220-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 31, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were AUTHORIZED by the precertification department of Broadspire."

Requestor's Supplemental Position Summary: "…We only received payment for on date of service…10/28/2015."

Amount in Dispute: $2,450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has reconsidered the bill and payment has been issued. We have attached the payment screen to show the two payments as well as the EOB."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2015 October 15, 2015 October 28, 2015 December 1, 2015	Chronic Pain Management Program – CPT Code 97799-CP-CA (25 hours)	$2,450.00	$1,950.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services The services in dispute were reduced/denied by the respondent with the following reason codes:
   - D49-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - 320-Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Did the requestor support position that preauthorization was obtained for services rendered on October 14 and 15, 2015?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the chronic pain management program rendered on October 14 and 15, 2015 based upon reason code "D49."

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

   A review of the submitted documentation indicates that the requestor obtained preauthorization for the following:

   - October 7, 2015: Chronic Pain Management Program, 80 hours, as an outpatient between October 6, 2015 and November 20, 2015.
   - November 10, 2015: Chronic Pain Management Program, 80 hours, as an outpatient between October 30, 2015 and December 14, 2015.

   The Division finds that dates of service October 14 and 15, 2015 fall within the preauthorized timeframe; therefore, the respondent's denial based upon reason code "D49" is not supported.

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 25 hours on the disputed dates 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. $125.00 x 25 hours = $3,125.00. The carrier paid $1,175.00. Therefore, the difference between the MAR and amount paid is $1,950.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,950.00.

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 $1,950.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		5/5/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN 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