



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

HEALTHCARE REHAB GROUP, INC.

Respondent Name

HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number

M4-16-2959-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

MAY 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have not received payment on any of these claims and when I called Broadspire the only people that I can speak with are the customer reps. I have asked to speak with bill review they have stated that their bill review department does not have a direct number and that the only way to reach them is through email."

Amount in Dispute: \$5,700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the above captioned medical fee dispute resolution. Payment has been made."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 19, 2016 through February 22, 2016; CPT Code 97799-CP-CA (38 hours) Chronic Pain Management Program; \$5,700.00; \$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

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 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.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- A19-Upon further review, additional payment is warranted.
- B79-Claims representative determined payment should be made.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

**Issues**

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

**Findings**

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

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 31 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.  $\$125.00 \times 38 \text{ hours} = \$4,750.00$ . The submitted explanation of benefits, support the respondent paid \$5,062.50 for the disputed services. Therefore, the requestor is not due any additional reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is not 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

08/31/2016  
\_\_\_\_\_  
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.**