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
HORIZON EVALUATORS, INC.

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3263-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The chronic pain management program (97799 CP) is broken down into two different 4 hour sections per day. The first 4 hour section [Claimant] attended the group therapy portion (1st 2 pages) and in the second 4 hour section [Claimant] performed the physical rehab portion of the program (last 3 pages) a total of 5 pages per day."

Requestor's Supplemental Position Summary: "Per the Texas Department of Insurance fee schedule, chronic pain management program is reimbursed at a $125 an hour for CARF accredited programs and $100 an hour for Non-CARF accredited programs. Seeing that each day is comprised of 8 hours and the facility is not CARF accredited the reimbursement should have been $800 a day."

Amount in Dispute: $425.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves the carrier's payment for date of service 7/14/2016 as it related to a chronic pain management program. The requester seeks an additional $425.00 for this. According to Rule 134.204(h)(5)(A) reimbursement is essentially time based. The requestor used a start time and an end time for the group processing activities. Each group took an hour as represented by the start and end time. The requestor then converted this to units. The total number of units for the group processing activities for each date was 225, which reflects 3.75 hours and not the four hours provided. Texas Mutual paid the group time based on the units billed, i.e. 225/60= 3.75X$100.00, or $375.00…Absent a more accurate reflection of the actual activities the claimant performed and the time of each activity performed versus lump sums such as 90 minutes, 80 minutes, 60 minutes, 66 minutes, and etc. Texas Mutual argues no additional payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2015	CPT Code 97799-CP X 8 hours Chronic Pain Management Program	$425.00	$355.00

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:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 725-Approved non network provider for Texas Star Network Claimant per Rule 1305.153(C).
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-18-Exact duplicate claim/service.
   - 736-Duplicate appeal. Network contract applied by Texas Star Network.

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) 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 requestor submitted Chronic Pain Management Daily Progress Note and Chronic Pain Management-Daily Activity Notes that indicate the claimant attended 4 hours of group psychotherapy and 3:30 hours of rehabilitation for a total of 7:30 hours.

The Division finds that the requestor billed CPT code 97799-CP for 7:30 hours. 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 7:30 hours documented is $730.00. The respondent paid $375.00. The Division finds the requestor is due additional reimbursement of $355.00.

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 $355.00.

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 $355.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		08/31/2016
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.