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
ULTIMATE PAIN SOLUTIONS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-18-2137-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "To date this case has never had any disputes in regard to the diagnosis."

Amount in Dispute: $37,865.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted By: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2017 July 25, 2017 July 26, 2017 September 29, 2017	CPT Code 99213-25 Office Visit	$125.00 X 4 = $500.00	$0.00
October 13, 2017 through November 10, 2017	CPT Code 97799-CP (107 hours) Chronic Pain Management Program	$37,365.00	$0.00
TOTAL		$37,865.00	$0.00

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 §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
3. The services in dispute were reduced or denied payment based upon reason code(s):

- 00164-(146)-Diagnosis was invalid for the date(s) of service reported.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 00950-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
- 00094-(26)-Expenses incurred prior to coverage.
- 18-Exact duplicate claim/service.
- W3-Request for reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the respondent's denial based upon invalid diagnosis supported?
2. Is the respondent's denial based upon "Expenses incurred prior to coverage" supported?
3. Does the documentation support billing CPT code 99213-25? Is the requestor entitled to reimbursement?
4. Does the documentation support billing CPT code 97799-CP? Is the requestor entitled to additional reimbursement ?

Findings

1. The fee guideline for office visits, CPT code 99213-25, is found in 28 Texas Administrative Code §134.203.

   28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The respondent denied services rendered on June 6, September 29, October 27 through November 10, 2017 based upon "00164-(146)-Diagnosis was invalid for the date(s) of service reported." A review of the submitted medical bills finds the diagnosis billed was "[redacted]" and "[redacted]." Per ICD10 coding, the respondent's denial is supported because "[redacted]" is not a valid code.

2. The explanation of benefits for date of service July 26, October 13 through October 18, 2017, finds the respondent denied reimbursement based upon "00094-(26)-Expenses incurred prior to coverage." The claimant sustained the compensable work injury on [redacted]. Therefore, the respondent's denial reason is not supported.

3. CPT Code 99213 is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   The requestor appended modifier -25 described as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

   28 Texas Administrative Code §133.307(c)(2)(M) states, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute."

Office visit reports for the above dates of service were not included in the dispute packet; therefore, the requestor did not support coding, billing and reporting CPT code 99213-25. As a result, reimbursement is not recommended.

4. The fee guideline for chronic pain management services, CPT code 97799-CP, is found in 28 Texas Administrative Code §134.230.

   28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required. (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 maximum allowable reimbursement (MAR). (B) 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 §134.230(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 division reviewed the explanation of benefits and submitted documentation and finds:

   - The requestor billed code 97799-CP; therefore, the disputed program is non-CARF accredited.
   - The requestor is seeking dispute resolution for 107 hours of CPT code 97799-CP.
   - Per the Table of Disputed Services, the Requestor is seeking dispute resolution for 24 hours of CPT code 97799-CP for November 8, 2017.
   - The November 8, 2017 medical bill does not support 24 hours was billed.
   - The requestor submitted medical records for dates of service: October 13, October 17, October 18, October 27 and November 1, 2017. These records do not indicate a start and end time to support the number of hours billed.
   - The requestor did not submit medical records for dates of service: October 24, October 25, November 2, November 3, November 8 and November 10, 2017 to support the number of units billed or the chronic pain management service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	7/18/2018 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.