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 & RECOVERY CLINIC OF NORTH HOUSTON

**Respondent Name**
SPRING ISD

**MFDR Tracking Number**
M4-18-3853-01

**Carrier's Austin Representative**
Box Number 43

**MFDR Date Received**
June 7, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "After requesting reconsideration in a timely fashion VIA mail to York Risk Services it is quite evident that the carrier is unwilling to reimburse our facility for services that were PREAUTHORIZED AND BILLED according to division rules."

**Amount in Dispute:** $3,000.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "... an ALJ opined the compensable injury did not necessitate the treatment made on the basis of this dispute. As such, the District is not liable for treatment for conditions determined not compensable by the ALJ."

**Response Submitted by:** Thornton Biechlin Reynolds & Guerra

## *SUMMARY OF DISPUTED SERVICE(S)*

| Date(s) of Service | Disputed Service(s) | Amount in Dispute | Amount Due |
|---|---|---|---|
| July 17, 2017 through July 27, 2017 | 97799-CP-CA x 6 | $3,000.00 | $3,000.00 |

## *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 medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the workers' compensation specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on extent of injury
   - Note: Billing unrelated to Workers' Compensation diagnosis
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration

## Issue(s)

1. Is the insurance carrier's denial reason supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

## Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP-CA rendered on July 17, 2017 through July 27, 2017. Per 28 Texas Administrative Code §133.307(d)(2)(F) states that " The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   Per 28 Texas Administrative Code 133.307 (d)(2)(H), states in pertinent part, "...Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements)."

   Review of the documentation submitted by the insurance carrier, finds that a copy of the PLN was not included to support its denial. The Division finds that the insurance carrier failed to support the denial of extent of injury. As a result, the disputed services are eligible for payment.

2. The requestor seeks reimbursement for CPT Code 97799-CP-CA rendered on July 17, 2017 through July 27, 2017.

   28 Texas Administrative Code §134.204 (h)(1)(A) states in pertinent part, "The following shall be applied to... Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) 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 MAR..."

   Review of the medical bills finds that the requestor billed CPT Code 97799-CP and appended modifier –CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement is calculated per 28 Texas Administrative Code §134.204 (h)(1)(A) for dates of service July 17, 2017 through July 27, 2017. Reimbursement for CARF accredited programs is calculated at 100% of the MAR.

3. The requestor billed CPT Code 97799-CP-CA rendered on July 17, 2017 through July 27, 2017. To determine reimbursement for a CARF accredited chronic pain management program, the division applies the following:

   28 Texas Administrative Code §134.204 (h) (5) (A) (B) "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 unit's 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."

   Review of the medical bills supports that the requestor billed modifier -CA supporting that the disputed services are CARF accredited. The calculation of the Maximum Allowable Reimbursement (MAR) for a CARF accredited chronic pain management program is indicated below:

| Date of Service | Submitted Code | Submitted Charges | Units | MAR | Paid Amount | Amount Due |
|---|---|---|---|---|---|---|
| July 17, 2017 | 97799-CP-CA | $500.00 | 4 | $125 x 4 = $500.00 | $0.00 | $500.00 |
| July 18, 2017 | 97799-CP-CA | $500.00 | 4 | $125 x 4 = $500.00 | $0.00 | $500.00 |
| July 24, 2017 | 97799-CP-CA | $500.00 | 4 | $125 x 4 = $500.00 | $0.00 | $500.00 |
| July 25, 2017 | 97799-CP-CA | $500.00 | 4 | $125 x 4 = $500.00 | $0.00 | $500.00 |
| July 26, 2017 | 97799-CP-CA | $500.00 | 4 | $125 x 4 = $500.00 | $0.00 | $500.00 |
| July 27, 2017 | 97799-CP-CA | $500.00 | 4 | $125 x 4 = $500.00 | $0.00 | $500.00 |
| Total | | $3,000.00 | | | $0.00 | $3,000.00 |

4. Review of the submitted documentation finds that the requestor is therefore entitled to reimbursement in the amount of $3,000.00. Therefore, this amount is recommended.

## 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 $3,000.00.

## *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 $3,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

| | | May 9, 2019 |
|---|---|---|
| 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**.