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

Respondent Name
HARTFORD INSURANCE COMPANY OF MIDWEST

MFDR Tracking Number
M4-18-4003-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JUNE 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As a result of this accreditation we are entitled to 100%of the MAR for Interdisciplinary Pain Rehabilitation Program (Chronic Pain Management) or $125.00 per hour."

Amount in Dispute: $125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is billing for 5 hours of treatment. However, the documentation only supports 4 hours."

Position Summary Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2018	Chronic Pain Management Program CPT Code 97799-CP-CA (Total of 5 Hours)	$125.00	$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, effective May 31, 2012 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 chronic pain management programs.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P5-Based on payer reasonable and customary fees, no maximum allowable defined by legislated fee arrangement.
   - B12-Services not documented in patients' medical records.
   - 00950-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Request for reconsideration.

Issues

Does the documentation support five (5) hours of chronic pain management services?

Finding

1. The fee guideline for chronic pain management services is found in 28 Texas Administrative Code §134.230.

2. According to the explanation of benefits, the respondent paid $500.00 based upon "B12-Services not documented in patients' medical records."

3. The respondent wrote, "The provider is billing for 5 hours of treatment. However, the documentation only supports 4 hours."

4. The requestor submitted Progress Notes dated April 2, 2018 that documents 60 minutes each of Educational Group, Nutrition/Socialization, Relaxation Information and Training, and Daily Activities, for a total of four (4) hours; therefore, the respondent's denial of payment for the additional one hour is supported.

Conclusion

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