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
ELITE HEALTHCARE SOUTH DALLAS

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-19-0147-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
SEPTEMBER 12, 2018

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid and has been returned due to reason: ''Services not documented in patients' medical records.' **This is incorrect. A detailed report was submitted on first submission on** 01/30/2018."

Amount in Dispute: $700.00

RESPONDENT'S POSITION SUMMARY

"The bill for DOS 01/23/18 has been reviewed and denial stands as per CMS Manual System Update effective 01/01/18. Per this update, 'Always Therapy' services to require the appropriate modifier in order for the service to be accurately applied to the therapy cap. Attached is the CMs bulletin for your review."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2018	CPT Code 97799-CP-GP (7 hours)	$700.00	$700.00

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 (DWC)

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
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 claim adjustment reason code(s):
    - B12-Services not documented in patient's medical records.
    - W3-Request for reconsideration.

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

Issues

Is the requestor entitled to reimbursement for chronic pain management program rendered on January 23, 2018?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $700.00 for chronic pain management program rendered on January 23, 2018.

2. The respondent wrote in position summary, "The bill for DOS 01/23/18 has been reviewed and denial stands as per CMS Manual System Update effective 01/01/18. Per this update, 'Always Therapy' services to require the appropriate modifier in order for the service to be accurately applied to the therapy cap. Attached is the CMs bulletin for your review."

   28 TAC §133.307(d)(2)(F) states, "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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   The DWC finds that the respondent raises issues in the position summary that were not presented to the requestor prior to the date the request for MFDR was filed with the DWC. A review of the submitted explanation of benefits does not list any denial reasons to support denial of payment due to missing modifiers or billing errors; therefore, the response was not submitted in accordance with 28 TAC §133.307. As a result, the disputed services will be reviewed per applicable DWC rules and guidelines.

3. According to the submitted explanation of benefits, the respondent denied payment for the chronic pain management program based upon "B12-Services not documented in patient's medical records."

   The requestor contends "T**his is incorrect. A detailed report was submitted on first submission."**

   A review of the submitted medical report supports the claimant participated in seven hours of chronic pain management program; therefore, the respondent's denial of payment is not supported.

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

5. 28 TAC §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."

   The requestor billed 97799-CP; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

6. 28 TAC §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 requestor billed CPT code 97799-CP for a non-CARF accredited chronic pain management program; therefore, the program shall be reimbursed at 80% of the MAR.

7. The requestor billed for 7 hours of 97799-CP; therefore, 80% of $125.00 = $100.00 X 7 hours = $700.00. The respondent paid $0.00. The requestor is due the difference of $700.00.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $700.00.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $700.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/11/2019
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.