



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

TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-19-1631-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

NOVEMBER 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was approved for the Chronic Pain Management Program. The service was provided and the claim was paid incorrectly. CPT code 97799 was paid below MAR."

Amount in Dispute: \$325.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider has been reimbursed all that is owed."

Response Submitted By: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2018	CPT Code 97799-CP-CA (5 hours)	\$325.00	\$325.00

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

- 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
- The services in dispute were reduced / denied by the respondent with the following reason codes:

- P12Workers' compensation jurisdictional fee schedule adjustment.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor due additional reimbursement for CPT code 97799-CP-CA?

Findings

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 submitted documentation and finds:

- The requestor billed for -CARF accredited chronic pain management program with code 97799-CP-CA.
- The requestor is seeking dispute resolution for 5 hours of CPT code 97799-CP-CA rendered from July 18, 2018.
- Per 28 Texas Administrative Code §134.230(1) and (5), the following formula is used to calculate the MAR: $100\% \text{ of } \$125.00 = \$125.00 \times 5 \text{ hours} = \625.00 . The respondent paid \$300.00. The requestor is due the difference between the MAR and amount paid of \$325.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$325.00.

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 \$325.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

12/13/2018
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.