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
NORTH TEXAS PAIN RECOVERY CENTER

MFDR Tracking Number
M4-19-2455-01

MFDR Date Received
January 8, 2019

Respondent Name
SAFETY NATIONAL CASUALTY CORP

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Gallagher Bassett has taken final action... and issued a denial of reimbursement, stating that authorization was denied at the time of the request. Utilization Review approval was received on September 25, 2018 for 80 hours of Division Return to Work Program 'Chronic Pain Management' ***to commence services*** between the dates of 9/21/2018 and 10/31/2018. These dates may also represent the dates requested by the provider for UR, however the UR approval #2953507 allows services to be rendered from 09/21/2018 through 12/21/2018 as demonstrated on the enclosed documentation... Services approved commended on 10/1/2018. Services denied herein occurred on 11/5/2018 and 11/6/2018 well within the DOS Start and the DOS End as indicated on the UR approval which bears the Preauthorization Number 2953507."

Amount in Dispute: $1,225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The denial is appropriate. This was denied after Utilization Review. The provider has attached documentation showing that only dates of service 9/21/18 – 10/31/18 are authorized for the requested number of hours."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 5, 2018 and November 6, 2018	97799-CP-CA x 2	$1,225.00	$875.00

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 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 Medical Fee Guideline for Workers' Compensation Specific Services.
4. 28 Texas Administrative Code §134.210 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification/pre-treatment absent
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Code(s) 97799-CP-CA x 2 rendered on November 5, 2018 and November 6, 2018. The insurance carrier in the position summary states in pertinent part, "197 – Precertification/authorization/notification/pre-treatment absent."

   28 Texas Administrative Code §134.600 (p) (12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   Review of the submitted documentation supports that the requestor obtained preauthorization for the disputed services, CPT Code 97799-CP. The requestor obtained preauthorization from Medinsights, dated September 21, 2018. The preauthorization letter indicates the following:

DOS Start	DOS End	Treatment	Item	Req Code	Req Units Visits	Auth Units Visits	Auth Code	Determination
09/21/2018	12/21/2018	Chronic Pain Management	Chronic Pain Management 97799 x 80 hrs start 9/21/18 thru 10/31/18	97799	10	10	97799	Nurse Approval

   28 Texas Administrative Code §134.600 (c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The disputed services were rendered on November 5, 2018 and November 6, 2018 within the authorized "DOS End" date of 12/21/2018. As a result, the requestor is entitled to reimbursement for the disputed services.

2. Per 28 Texas Administrative Code §134.210 (e)(1) (2) "(e) The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs--This modifier shall be used when a health care provider bills for a return to work rehabilitation program that is CARF accredited. (2) CP, chronic pain management program--This modifier shall be added to CPT code 97799 to indicate chronic pain management program services were performed."

   Per 28 Texas Administrative Code §134 .204 (h)(1) "The following shall be applied to Return to Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, 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."

   Per 28 Texas Administrative Code §134 .204 (h)(5) "The following shall be applied to Return to Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, 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. (5) 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 submitted documentation 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)(5).

The calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
November 5, 2018	97799-CP-CA	$700.00	4	$125 x 4 = $500.00	$0.00	$500.00
November 6, 2018	97799-CP-CA	$525.00	3	$125 x 3 = $375.00	$0.00	$375.00
Total		$1,225.00	7	$875.00	$0.00	$875.00

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $875.00, 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 $875.00.

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 $875.00 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	April 18, 2019 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.