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
VALLEY FORGE INSURANCE COMPANY

MFDR Tracking Number
M4-19-2672-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
January 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills and proper clinical documentation in a timely fashion according to all TDI rules and regulations. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $2,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier is in the process of issuing payment … in the amount of $625.00 + $7.28 interest for a total of $632.28 … payment was issued on 1/24/2019 … in the amount of $1625.00."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 25, 2018 to September 25, 2018	Chronic Pain Management	$2,500.00	$250.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.230 sets out fee guidelines for chronic pain management services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P300 – The amount paid reflects a fee schedule reduction.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 198 – Precertification/authorization exceeded.
   - 198 – Precertification/notification/authorization/pre-treatment exceeded.
   - MA04 – Number of occurrences on Authorization record has been exceeded.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 198 – Precertification/authorization exceeded.
   - 198 – Precertification/notification/authorization/pre-treatment exceeded.
   - MA04 – Number of occurrences on Authorization record has been exceeded.

   However, upon appeal, the insurance carrier did not maintain these denial reasons after reconsideration. The division therefore concludes these denial reasons are not supported. Consequently, the disputed services will be reviewed for reimbursement in accordance with division rules and fee guidelines.
2. This dispute regards chronic pain management services with reimbursement subject to the Medical Fee Guideline for Return to Work Rehabilitation Programs, 28 Texas Administrative Code §134.230(5)(A) requiring the program be billed using code 97799 with modifier "CP." CARF accredited programs shall add "CA" as a second modifier. Per Rule §134.230(5)(B), reimbursement shall be $125 per hour, prorated to the nearest 15-minute increment. Per Rule §134.230(1)(A), CARF accredited programs are reimbursed at 100% of the maximum allowable (MAR).

   Reimbursement is calculated as follows:

   - For code 97799-CP-CA-GP, July 25, 2018, the provider billed 6.5 hours. The records support the units billed. This amount multiplied by $125.00 results in a MAR of $812.50.
   - For code 97799-CP-CA-GP, August 7, 2018, the provider billed 6.5 hours. The records support the units billed. This amount multiplied by $125.00 results in a MAR of $812.50.
   - For code 97799-CP-CA-GP, September 12, 2018, the provider billed 5.5 hours. The records support the units billed. This amount multiplied by $125.00 results in a MAR of $687.50.
   - For code 97799-CP-CA-GP, September 24, 2018, the provider billed 7 hours. The records support the units billed. This amount multiplied by $125.00 results in a MAR of $875.00.
   - For code 97799-CP-CA-GP, September 25, 2018, the provider billed 6.5 hours. The records support the units billed. This amount multiplied by $125.00 results in a MAR of $812.50.

   The total allowable reimbursement for the services in dispute is $4,000. The insurance carrier has paid $3,750 toward the disputed services (not including additional paid interest of $7.28, for a total of $3,757.28), leaving a balance due to the requestor of $250.00. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes the findings in this decision are based on the available evidence presented by the requestor and respondent up to the time of review. Even though not all the evidence was discussed, it was considered.

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 $250.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $250.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 29, 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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.