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 AND RECOVERY CLINIC

Respondent Name
TEXAS DEPARTMENT OF TRANSPORTATION

MFDR Tracking Number
M4-19-4016-01

Carrier's Austin Representative
Box Number 32

MFDR Date Received
May 2, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bills originally mailed to Texas Department of Transportation (EOR's-attached with recommended allowance and the carrier never paid, date of service 1/17/19 has no EOB because the carrier DELETED original EOB with recommended allowance)."

Amount in Dispute: $5,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Division should dismiss the request because Requestor has not met the prerequisite for MFDR... Payment is not owed because the treatment was for a non-compensable condition... The Division should dismiss the request for MFDR because Requestor did not submit a proper request for reconsideration prior to requesting MFDR. In the alternative, the Division should find that Requestor is not entitled to payment because the service was provided for a condition that is not part of the compensable injury."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
January 9, 2019 through February 1, 2019	97799-CP-CA-GP x 9	$5,750.00	$5,750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 fee guidelines for the workers' compensation specific services.
4. The insurance carrier reduced/denied payment with the following claim adjustment codes:
   - P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier
   - 247 – A payment or denial has already been recommended for this service
   - P4 – Workers' Compensation claim adjudicated as non-compensable. This payer is not liable for claim or service/treatment
   - 96 – Non-covered charge(s)

Issue(s)

1. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor obtain preauthorization for the disputed services?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for dates of service January 9, 2019 through February 1, 2019. Per 28 Texas Administrative Code §133.307 (d) (2) (F) states that "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."

   The insurance carrier's position summary states in part, "The Division should dismiss the request because Requestor has not met the prerequisite for MFDR... Payment is not owed because the treatment was for a non-compensable condition..."

   The insurance carrier presented to MFDR, copies of EOBs dated May 6, 2019, May 9, 2019 and May 15, 2019. The DWC-60 request was received in MFDR on May 2, 2019.

   The Division concludes that the respondent has not met the requirements of 133.307 (d) (2) (F). The new denial defense reasons raised after the MFDR submission are therefore not supported for date(s) of service January 9, 2019 through February 1, 2019**.** The disputed service(s) are therefore reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   Per 28 Texas Administrative Code §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor submitted a copy of a preauthorization letter issued by IMO, dated January 7, 2019. The preauthorization letter indicates that the following services were preauthorized:

CPT	Description	Request Date	Determination Date	Status	Authorization	Dates of Service
97799	Chronic Pain, per hour	01/02/19	01/07/19	Preauthorized	121028	1/7/19 – 3/7/19

   The division finds that the disputed services rendered on January 9, 2019 through February 1, 2019 were rendered within the preauthorized timeframe. As a result, the requestor is entitled to reimbursement. Reimbursement is therefore determined per 28 Texas Administrative Code §134.204 (h)(1)(A-B) and §134.204 (h) (5) (A) (B).

3. Per 28 Texas Administrative Code §134.204 (h)(1)(A-B) states in pertinent part, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of... 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..."

   To determine reimbursement for a chronic pain management program, the division applies the following:

   28 Texas Administrative Code §134.204 (h) (5) (A) (B) "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-CA 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) for dates of service January 9, 2019 through February 1, 2019. Reimbursement for CARF accredited programs is calculated at 100% of the MAR for each date of service.

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

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
January 9, 2019	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$0.00	$687.50
January 14, 2019	97799-CP-CA	$562.50	4.5	$125 x 4.5 = $562.50	$0.00	$562.50
January 15, 2019	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$0.00	$687.50
January 17, 2019	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$0.00	$687.50
January 18, 2019	97799-CP-CA	$500.00	4	$125 x 4 = $500.00	$0.00	$500.00
January 21, 2019	97799-CP-CA	$625.00	5	$125 x 5 = $625.00	$0.00	$625.00
January 22, 2019	97799-CP-CA	$750.00	6	$125 x 6 = $750.00	$0.00	$750.00
January 24, 2019	97799-CP-CA	$625.00	5	$125 x 5 = $625.00	$0.00	$625.00
February 1, 2019	97799-CP-CA	$625.00	5	$125 x 5 = $625.00	$0.00	$625.00
TOTAL		$5,750.00	46	$125 x 46 = $5,750.00	$0.00	$5,750.00

4. Review of the submitted documentation finds that the requestor is entitled to a total reimbursement amount of $5,750.00. As a result, 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 $5,750.00.

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 $5,750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 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, 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 (20)** 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.