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
M4-19-4493-01

Carrier's Austin Representative
Box Number 32

MFDR Date Received
June 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bills originally mailed to Texas Department of Transportation (EOR's-attached.) The services were AUTHORIZED by the precertification department for the compensable injury which was approved upon peer review and is not subject to retrospective review which clearly violates Texas Labor Code 134.600... We feel that our facility should be paid according to the fee schedule guidelines of a CARF accredited facility."

Amount in Dispute: $2,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response was received.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
June 19, 2018 through August 2, 2018	97799-CP-CA-GP x 9	$2,750.00	$2,750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §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:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 96 – Non-covered charge(s)
   - 167 – These diagnoses are not covered

Issue(s)

1. Did the insurance carrier respond to the medical fee dispute?
2. Is there unresolved compensability, extent of injury or liability issues for date of service July 24, 2018, July 26, 2018, July 31, 2018, and August 2, 2018 ?
3. Are the insurance carrier's denial reasons "309 , P12, and 1001," supported for dates of service June 19, 2018, June 22, 2018, July 3, 2018, July 6, 2018 and July 20, 2018?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Texas Department of Transportation is Texas Department of Transportation. Texas Department of Transportation acknowledged receipt of the copy of this medical fee dispute on June 21, 2019. Per 28 TAC §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1)

2. The insurance carrier denied the chronic pain management services rendered on July 24, 2018, July 26, 2018, July 31, 2018, and August 2, 2018 with claim adjustment reason code "96 – Non-covered charge(s)" and "167 – These diagnoses are not covered."

   The insurance carrier did not submit a response to the DWC060 request and therefore did not submit copies of a PLN-11, as required by 28 TAC $133.307(d)(2)(H) and in accordance with 28 TAC §124.2. 28 TAC §124.2(h), which requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   28 TAC §133.307(d)(2)(H) further requires that If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with 28 TAC §124.2 (relating to carrier reporting and notification requirements). The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of 28 TAC §133.307(d)(2)(H) regarding notice of issues of liability, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability or liability for the disputed services.

3. The insurance carrier issued partial payments for the chronic pain management services rendered on June 19, 2018 through July 20, 2018 and denied the remaining units with denial reason codes "309 , P12, and 1001" (descriptions provided above.) To determine the MAR for CPT Code 97799-CP-CA the DWC applies the following:

   28 TAC §134.204 (h)(1)(A-B) which 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 DWC applies the following:

   28 TAC §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 TAC §134.204 (h) for dates of service June 19, 2018 through August 2, 2018. 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
June 19, 2018	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$625.00	$62.50
June 22, 2018	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$625.00	$62.50
July 3, 2018	97799-CP-CA	$562.50	4.5	$125 x 4.5 = $562.50	$500.00	$62.50
July 6, 2018	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$625.00	$62.50
July 20, 2018	97799-CP-CA	$562.50	4.5	$125 x 4.5 = $562.50	$500.00	$62.50
July 24, 2018	97799-CP-CA	$500.00	4	$125 x 4 = $500.00	$0.00	$500.00
July 26, 2018	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$0.00	$687.50
July 31, 2018	97799-CP-CA	$687.50	5.5	$125 x 5.5 = $687.50	$0.00	$687.50
August 2, 2018	97799-CP-CA	$562.50	4.5	$125 x 4.5 = $562.50	$0.00	$562.50
TOTAL		$5,625.00	45	$125 x 45 = $5,625.00	$2,875.00	$2,750.00

The DWC finds that the insurance carrier's reduction for the chronic pain management services are not supported and the requestor is therefore entitled to additional reimbursement in the amount of $2,750.00

4. Review of the submitted documentation finds that the requestor is entitled to a total reimbursement amount of $2,750.00. 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 $2,750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC 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 $2,750.00 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20, 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 TAC §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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.