



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

FUNCTIONAL PAIN CENTER

**Respondent Name**

EMPLOYERS PREFERRED INSURANCE COMPANY

**MFDR Tracking Number**

M4-19-5156-01

**Carrier's Austin Representative**

Box Number 04

**MFDR Date Received**

August 9, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Services rendered were for COMPENSABLE body part... No treatment was provided for any other body part. Enclosed please refer to the Contested Case Hearing Decision and Order... All rendered services were certified by Prium Insurance. FPC has taken all appropriate measures to ensure that treatment was rendered to the appropriate body part after following the necessary protocol to receive authorization to treat the patient. We would like to be fully reimbursed for the authorized services we provided..."

**Amount in Dispute:** \$29,040.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "MFDR should dismiss the August 16, 2019 [sic] Request... The Appeals Panel Decision regarding extent of injury is dated June 3, 2019 and is deemed received five days after mailing. The Requestor was required to file the request for MFDR by August 6, 2019. The MFDR date stamp on the Request shows that the Request was received by MFDR on August 9, 2019, more than 60 days after receipt of the Appeals Panel Decision. The Requestor has waived its right for MFDR, and the Request should be dismissed."

**Response Submitted by:** Ricky D. Green, PLLC

#### SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
June 22, 2018 through September 11, 2018	96150 and 97799-CP-CA	\$29,040.00	\$24,183.20

#### FINDINGS AND DECISION

This medical fee dispute (MFD) 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. 28 TAC §102.4 sets out the rules for non-Commission communications.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 6516 – Services rendered are unrelated to the claim
  - 6518 – Non-Covered charges
  - 6536 – Unrelated to admitted body part(s) or diagnosis
  - 6532 – Absence of or exceeds precertification/ authorization

**Issue(s)**

1. Did the requestor submit the dispute timely and in accordance with 28 TAC 133.307(c)(1)(B)?
2. Did the requestor obtain preauthorization for the disputed services?
3. What is the applicable rule for determining reimbursement for the chronic pain management services?
4. What is the applicable rule for determining reimbursement for CPT Code 96150?
5. Is the requestor entitled to reimbursement?

**Findings**

1. The requestor seeks reimbursement for CPT Code 96150 rendered on June 22, 2018 and chronic pain management services, CPT Code 97799-CP-CA, rendered on July 5, 2018 through September 11, 2018. The insurance carrier denied the disputed services with denial reason(s) code(s): “6516 – Services rendered are unrelated to the claim; 6518 – Non-Covered charges and 6536 – Unrelated to admitted body part(s) or diagnosis.”

28 TAC §133.305(b) requires that “...If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.”

The MFD may be submitted for review as a new dispute that is subject to the requirements of 28 TAC §133.307. 28 TAC §133.307 (c)(1)(B) provides that a request for MFD resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The requestor submitted a copy of an Appeals Panel decision dated, June 3, 2019. The DWC’s MFDR received the DWC060 request on August 9, 2019.

28 TAC §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.”

The DWC finds that the requestor submitted the DWC060 request timely and within the 60 days after the receipt of the final decision. As a result, the disputed services are reviewed pursuant to the applicable rules.

2. The disputed service was denied with denial reduction code “6532 – Absence of or exceeds precertification/ authorization.” Per 28 TAC §134.600 “(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation.”

Per 28 TAC §134.600 “(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program.”

The requestor submitted a copies of preauthorization letters issued by Prium, dated, June 19, 2018, July 26, 2018, August 16, 2018, September 27, 2018 and September 27, 2018. The following services were preauthorized:

Preauthorization #	6004690
Date:	June 19, 2018
Requested Procedure/Service:	1 psychological evaluation (CPT Code 96150 Assess hlth/behavior, initial) between 6/18/2018 and July 18, 2018
Determination:	Recommend prospective request for 1 psychological evaluation (CPT Code: 96150 Assess hlth/behavior, initial) between 6/18/2018 and 7/18/2018 be certified 30 Days

Preauthorization #	6006197
Date:	July 26, 2018
Requested Procedure/Service:	80 hours of interdisciplinary pain rehab (8 hours per day, 5 days per week for 2 weeks. Total 80 hours) (CPT Code: 97799) between 7/25/2018 and 8/24/2018
Determination:	Recommend prospective request for 80 hours of interdisciplinary pain rehab (8 hours per day, 5 days per week for 2 weeks. Total 80 hours) (CPT Code: 97799) between 7/25/2018 and 8/24/2018 be certified 30 Days

Preauthorization #	6007068
Date:	August 16, 2018
Requested Procedure/Service:	80 hours of interdisciplinary pain rehab (8 hours per day, 5 days per week for 2 weeks) (CPT Code: 97799) between 8/15/2018 and 9/14/2018.
Determination:	Recommend prospective request for 80 hours of interdisciplinary pain rehab (8 hours per day, 5 days per week for 2 weeks) (CPT Code: 97799) between 8/15/2018 and 9/14/2018 be certified. 30 Days

Preauthorization #	6008725
Date:	September 27, 2018
Requested Procedure/Service:	20 days interdisciplinary pain rehab program (CPT Code: 97799) between 7/5/2018 and 9/11/2018
Determination:	Recommend retrospective request for 20 days interdisciplinary pain rehab program (CPT Code: 97799) between 7/5/2018 and 9/11/2018 be certified 30 Days

Preauthorization #	6008726
Date:	September 27, 2018
Requested Procedure/Service:	4 aftercare sessions for interdisciplinary pain rehab program (8 hours per day, 1 day per week for 4 weeks) (CPT Code: 97799) between 8/24/2018 and 9/11/2018
Determination:	Recommend retrospective request for 4 aftercare sessions for interdisciplinary pain rehab program (8 hours per day, 1 day per week for 4 weeks) (CPT Code: 97799) between 8/24/2018 and 9/11/2018 be certified 30 Days

28 TAC §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 DWC finds that the disputed services were preauthorized and therefore, the requestor is entitled to reimbursement for CPT Codes 96150 and 97799-CP-CA.

3. To determine reimbursement for a chronic pain management program, the DWC applies the following:

28 TAC §134.204 (h)(1) states in pertinent part, “The following shall be applied to... Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a DWC 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.”

28 TAC §134.204 (h) (1) (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...”

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 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 July 5, 2018 through September 11, 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:

Preauthorization Number	DOS	CPT Code	Billed Charge	Unit(s)	MAR	Paid Amount	Amount Due
6008725	7/5/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/9/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/12/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/13/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/16/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/17/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/18/18	97799-CP-CA	\$900.00	6	\$125 X 6 = \$750.00	\$0.00	\$750.00
6008725	7/19/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/20/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6008725	7/23/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	7/27/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	7/30/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	7/31/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/1/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/2/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/3/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/8/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/9/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/10/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6006197	8/13/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6007068	8/24/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6007068	8/28/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6007068	9/4/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
6007068	9/11/18	97799-CP-CA	\$1,200.00	8	\$125 x 8 = \$1,000.00	\$0.00	\$1,000.00
Total	Total		\$29,040.00				\$23,750.00

- The requestor seeks reimbursement for CPT Code 96150 rendered on June 22, 2018. TAC §134.203 (b) states in pertinent part, “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers’ compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

CPT Code 96150 is defined as “Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.”

28 TAC §134.203 states in pertinent part, “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...”

Procedure code 96150, June 22, 2018, has a Work RVU of 0.5 multiplied by the Work GPCI of 1 is 0.5. The practice expense RVU of 0.11 multiplied by the PE GPCI of 0.938 is 0.10318. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.6191 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$36.10 at 12 units is \$433.20. Therefore, this amount is recommended.

5. Review of the submitted documentation finds that the requestor is therefore entitled to a total reimbursement amount of \$24,183.20.

### **Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$24,183.20.

### ***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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$24,183.20 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	December 13, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this MFD 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 an MFD Decision form DWC045M** in accordance with the instructions on the form. The request must be received by the DWC within **twenty (20)** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **Please include a copy of the MFD 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.**