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
PAIN AND RECOVERY CLINIC

Respondent Name
EASTGUARD INSURANCE CO

MFDR Tracking Number
M4-19-5200-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
AUGUST 14, 2019

REQUESTOR'S POSITION SUMMARY

"Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for lack of precertification."

Amount in Dispute: $4,812.50

RESPONDENT'S POSITION SUMMARY

"I have reviewed the 6 dates of service that were in question and all bills have been sent back for reprocessing. When these bills were entered into the system, they were entered with units billed instead of minutes to process correctly. I have made the correction to these bills and all are currently processing correctly."

Response Submitted By: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2019 June 12, 2019 June 13, 2019 June 14, 2019 June 17, 2019 June 18, 2019	CPT Code 97799-CP-CA-GP (38.5 hours)	$4,812.50	$187.50

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 (DWC)

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement

guidelines for return to work rehabilitation programs.

3. The services in dispute were reduced or denied payment based upon claim adjustment reason code(s):
    - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 350-Bill has been identified as a request for reconsideration or appeal.
    - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to reimbursement for chronic pain management program rendered on May 29 and 30, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,625,00 for chronic pain management program rendered from June 7, 2019 through June 18, 2019.

2. The respondent paid $4,625.00 for the disputed chronic pain management program based upon the fee guideline.

3. The requestor contends that reimbursement is due because the disputed chronic pain management program was preauthorized. In support of their position, the requestor submitted a copy of a preauthorization report from Coventry dated June 6, 2019 authorizing 40 hours of chronic pain management program.

4. The fee guideline for chronic pain management services is found in 28 Texas Administrative Code §134.230.

5. 28 TAC §134.230(1)(A) states "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 maximum allowable reimbursement (MAR). (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

6. 28 TAC §134.230(5) states, "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 units 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."

   The requestor billed 97799-CP-CA-GP; therefore, the disputed program is CARF accredited and reimbursement shall be 100% of the MAR.

   The requestor billed for a total of 38.5 hours on the disputed dates of service; therefore, 100% of $125.00 = $125.00 X 38.5 hours = $4,812.50. The respondent paid $4,625.00. The requestor is due the difference of $187.50.

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 $187.50.

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 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 $187.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/11/2019
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, 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 DWC within **twenty** 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 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 DWC. **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.