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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-20-0304-01

Carrier's Austin Representative Box
Number 19

Fee Dispute Request Received
October 1, 2019

Response Submitted by:
Gallagher Bassett

REQUESTOR POSITION SUMMARY

"Gallagher Bassett did forward this bill to another bill processing agent, MedRisk who incorrectly processed the bill and reduced the Division mandated reimbursement amount by 60%... Gallagher Bassett is liable for an additional amount of $3,000.00 for the enclosed bill."

Amount in Dispute: $4,650.00

RESPONDENT POSITION SUMMARY

"…we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF DISPUTED SERVICE(S)

Dates of Service	Disputed Service	Disputed Amount	Amount Due
June 17, 2019 through June 21, 2019	97799-CP-CA	$4,650.00	$2,750.00

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 §133.240 sets out requirements for paying or denying medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
4. Texas Insurance Code Chapter 1305 regulates certified workers' compensation health care networks.
5. Texas Labor Code Sections 413.011(d-1) to (d-6) [expired] and 413.0115, as well as former division Rule at 28 Texas Administrative Code §133.4, set out certain provisions related to informal and voluntary insurance networks.
6. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is reduced.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 01 – The charge for the procedure exceeds the amount indicated in the fee schedule
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
    - NR – A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated rate
    - Note: This bill has been repriced according to your contract with the above noted PPO Network

Issue(s)

1. Are the insurance carrier's reasons for reduction of payment supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP-CA, rendered on June 17, 2019 through June 21, 2019. The requestor indicates that, "Gallagher Bassett did forward this bill to another bill processing agent, MedRisk who incorrectly processed the bill and reduced the Division mandated reimbursement amount by 60%... Gallagher Bassett is liable for an additional amount of $3,000.00 for the enclosed bill."

   Review of the documentation provided by the insurance carrier revealed that the carrier submitted insufficient documentation to support that a contract exists between the requestor and the carrier. Therefore, the carrier's reduction is unsupported. The DWC finds that the disputed services are payable pursuant to 28 TAC §134.204.

2. 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 June 17, 2019 through June 21, 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:

DOS	CPT Code	Billed Charge	Unit(s)	MAR	Paid Amount	Amount Due
6/17/2019	97799-CP-CA	$1,400.00	8	$125 x 8 = $1,000.00	$400.00	$600.00
6/18/2019	97799-CP-CA	$1,400.00	8	$125 x 8 = $1,000.00	$400.00	$600.00
6/19/2019	97799-CP-CA	$1,400.00	8	$125 x 8 = $1,000.00	$400.00	$600.00
6/20/2019	97799-CP-CA	$1,050.00	6	$125 x 6 = $750.00	$400.00	$350.00
6/21/2019	97799-CP-CA	$1,400.00	8	$125 x 8 = $1,000.00	$400.00	$600.00
Total		$6,650.00	38	$4,750.00	$2,000.00	$2,750.00

3. Review of the submitted documentation finds that the MAR reimbursement is $4,750.00, the insurance carrier paid $2,000.00 and therefore, the requestor is entitled to an additional reimbursement in the amount of $2,750.00.

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 $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 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 $2,750.00 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.