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
ELITE HEALTHCARE FORT WORTH

Respondent Name
ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-20-0638-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 8, 2019

REQUESTOR'S POSITION SUMMARY

"Carrier isn't paying accordingly to authorization our facility received."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

"Only 6 hours of service are documented in the reports."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2019	CPT Code 97799-CP-GP (8 hours)	$200.00	$200.00

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):
    - B12-Services not documented in patient's medical records.
    - W3-Request for reconsideration.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for chronic pain management program rendered on April 23, 2019?

Findings

1. The requestor billed for eight hours of chronic pain management services rendered on April 23, 2019. The respondent paid for six hours based upon "B12-Services not documented in patient's medical records." The requestor is seeking additional reimbursement for the unpaid two hours.

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

3. The submitted medical report supports the claimant participated in eight hours of chronic pain; therefore, the respondent's denial of payment is not supported.

4. 28 TAC §134.230(1) 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."

   The requestor billed 97799-CP-GP; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

5. The requestor billed for 8 hours; therefore, 80% of $125.00 = $100.00 X 8 hours = $800.00. The respondent paid $600.00. The requestor is due the difference of $200.00

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $200.00.

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 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 $200.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/26/2019 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 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.