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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-20-0692-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier owes North Texas Pain Recovery Center for DOS' 3-11-2019 thorough [sic] 3-15-2019 for 40 hours of chronic pain Management. All other dates have been paid. North Texas Pain Recovery will certainly withdraw our request where no real dispute exists. However there remains a balance of $5000.00 MAR for the dates mentioned above."

Amount in Dispute: $13,563.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that the provider's DWC-60 has billed the Chronic Pain Management Program at $175 per hour when the maximum rate is $125 per hour… The carrier has either paid or is in the process of paying those amounts as well as the other dates of service as $125 per hour. The carrier is also paying interest."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 23, 2019 through March 25, 2019	90791 and 97799-CP-CA	$13,563.02	$5,000.00

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 §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers Compensation jurisdictional fee schedule adjustment
   - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
   - 5085 – Payment is denied as the billed diagnosis is not allowed in this claim

Issues

1. Does the requestor continue to pursue MDR for dates of service March 11, 2019 through March 15, 2019?
2. Did the insurance carrier issue a partial payment to the requestor?
3. Is the requestor entitled to reimbursement for dates of service March 11, 2019 through March 15, 2019 and March 25, 2019?

Findings

1. The requestor, Brian Shepler submitted a supplemental response dated December 3, 2019 indicating the following, "The carrier owes North Texas Pain Recovery Center for DOS' 3-11-2019 thorough [sic] 3-15-2019 for 40 hours of Chronic Pain Management. All other dates have been paid… However there remains a balance of $5000.00 MAR for dates mentioned above."

   The insurance carrier states in pertinent part, "The carrier has either paid or is in the process of paying those amounts as well as the other dates of service as $125 per hour. The carrier is also paying interest."

   Review of the submitted documentation finds that the insurance carrier has not issued a payment for dates of service, March 11, 2019 through March 15, 2019, therefore, the requestor continues to pursue reimbursement for these dates of service. The DWC finds that the insurance carrier is no longer affirming the denial reasons provided on the EOBs, and the requestor is therefore entitled to additional reimbursement for services rendered on March 11, 2019 through March 15, 2019. As a result, the DWC will issue a findings and decision for these dates of service.

2. The requestor seeks reimbursement for dates of service, March 11, 2019 through March 15, 2019. 28 TAC §134.204 (h)(1)(A) states in pertinent part, "(h) The following shall be applied to… Chronic Pain Management… 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."

   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)(1)(A).

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

   28TAC §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 CMS-1500s and the medical documentation finds that the requestor billed the following:

   Date of service March 11, 2019, the requestor billed and documented 8 hours and is therefore entitled to reimbursement in the amount of $125.00 x 8 hours = $1,000.00. Therefore, this amount is recommended.

   Date of service March 12, 2019, the requestor billed and documented 8 hours and is therefore entitled to reimbursement in the amount of $125.00 x 8 hours = $1,000.00. Therefore, this amount is recommended.

   Date of service March 13, 2019, the requestor billed and documented 8 hours and is therefore entitled to reimbursement in the amount of $125.00 x 8 hours = $1,000.00. Therefore, this amount is recommended.

   Date of service March 14, 2019, the requestor billed and documented 8 hours and is therefore entitled to reimbursement in the amount of $125.00 x 8 hours = $1,000.00. Therefore, this amount is recommended.

   Date of service March 15, 2019, the requestor billed and documented 8 hours and is therefore entitled to reimbursement in the amount of $125.00 x 8 hours = $1,000.00. Therefore, this amount is recommended.

   The DWC finds that the requestor is entitled to a total reimbursement amount of $5,000.00, therefore this amount is recommended.

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 $5,000.00.

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 $5,000.00 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		February 7, 2020
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 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 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 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 *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.