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
NUEVA VIDA BEHAVIORAL HEALTH ASSOCITAES, INC.

Respondent Name
AMERICAN INTERSTATE INSURANCE

MFDR Tracking Number
M4-20-1258-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 21, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization was obtained prior to the services being performed… At this time, I ask that you please review the attached documentation and recommend payment for the above-mentioned dates of service."

Amount in Dispute: $1,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based upon the attached review, Amerisafe has determined treatment is not reasonable or necessary. Therefore, we have denied dates of service 8/28/19—8/30/19."

Response Submitted by: Amerisafe Risk Services, Inc.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
August 28, 2019 and August 30, 2019	97799-CP	$1,600.00	$1,600.00

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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.230 sets out the fee guidelines for Return to Work Rehabilitation Programs.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers Compensation jurisdictional fee schedule adjustment
   - P15 – Workers Compensation Medical Treatment Guideline
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulation or payment policies
   - 216 – Based on the findings of a review organization
   - ASPE – Treatment not reasonable or necessary based upon peer review

Issue(s)

1. Did the requestor submit documentation to support that CPT Code 97799 rendered on August 28, 2019 and August 30, 2019 was preauthorized?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP rendered on August 28, 2019 and August 30, 2019. The insurance carrier denied the disputed service with denial reduction code, "216 – Based on the findings of a review organization" and "ASPE – Treatment not reasonable or necessary based upon peer review."

   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 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor submitted a copy of a preauthorization letter issued by York, dated August 1, 2019 documenting the following:

Services Requested:	Functional Restoration Program (FRP) 80 hours, 97799
Determination:	Certified
Services Approved from:	8/1/2019 – 11/30/2019

   The DWC finds, that the services were rendered on August 28, 2019 and August 30, 2019, within the preauthorized timeframes. As a result, the insurance carrier's denial reasons are not supported, and the requestor is entitled to reimbursement pursuant to 28 TAC §134.230.

2. The fee guideline for chronic pain management services, CPT code 97799-CP, is found in 28 TAC §134.230.

   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."

   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 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.

   The division reviewed the submitted documentation and finds:
   - The requestor billed for a non-CARF accredited chronic pain management program with code 97799-CP.
   - The requestor is seeking dispute reimbursement for 16 hours of CPT code 97799-CP rendered on August 28, 2019 and August 30, 2019.
   - Per 28 Texas Administrative Code §134.230(1) and (5), the following formula is used to calculate the MAR: 80% of $125.00 = $100.00 X 16 hours = $1,600.00. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $1,600.00.

3. Review of the submitted documentation finds that the requestor is entitled to a total reimbursement amount of $1,600.00, 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 $1,600.00.

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 $1,600.00 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.