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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
WORK FIRST CASUALTY CO

MFDR Tracking Number
M4-20-1310-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 24, 2020

REQUESTOR'S POSITION SUMMARY

"Enclosed are copies of the EOB and claim. The claim was denied per EOB unnecessary treatment based on peer review. Per DWC Rule 133.301(a), the insurance carrier shall not retrospectively review the medical necessiry of a medical bill for treatment(s) and/or services(s) for which the medical care provider has obtained preauthorization under rule 134.600(h). CPT code 97799CPCA was preauthorized, #702422 therefore it is deemed medically necessary."

Amount in Dispute: $1,625.00

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2019 May 10, 2019	Chronic Pain Management Program CPT Code 97799 CP-CA (6.5 hours per day X 2 = 13 hours)	$812.50/day X 2 = $1,625.00	$1,625.00

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 §133.307 (TAC), effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. 28 TAC §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
4. Per the submitted explanation of benefits, the services in dispute were reduced/denied payment by the respondent with the following claim adjustment reason codes:

   - V-Unnecessary Treatment (w/Peer Review).

- D51-Unnecessary Treatment based on peer review.

Issues

Does a medical necessity issue exist in this dispute? Is the requestor entitled to reimbursement for services rendered May 9 and 10, 2019?

Findings

1. The Austin carrier representative for Work First Casualty Co is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on January 31, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requestor is seeking medical fee dispute resolution in the amount of $1,625.00 for chronic pain management program rendered on May 9 and 10, 2019.

3. The respondent denied reimbursement for chronic pain management program rendered on May 9 and 10, 2019 based upon medical necessity.

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

5. 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-CA; therefore, the disputed program is CARF accredited and reimbursement shall be 100% 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.”

7. The requestor billed for 13 hours; therefore, 100% of $125.00 = $125.00 X 13 hours = $1,625.00. The respondent paid $0.00. As a result reimbursement of $1,625.00 is recommended.

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 $1,625.00.

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 Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,625.00 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	04/03/2020 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, 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.