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
PRC HEALTH SERVICES, LLC

Respondent Name
GREAT AMERICAN ALLIANCE INSURANCE CO

MFDR Tracking Number
M4-20-1537-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 19, 2020

REQUESTOR'S POSITION SUMMARY

"Our facility has made several attempts to obtain reimbursement for services authorized by the carrier on the above mentioned patient…We properly billed the DOS (10/7/19, 10/25/19, 10/31/19, 11/1/19) in question and performed request for reconsideration. The services in question have been approved by the carrier's utilization review department…We obtained preauthorization according to division rules and regulations. We feel that our facility should be paid according to the correct fee schedule guidelines."

RESPONDENT'S POSITION SUMMARY

"The provider has been reimbursed $400 for the October 7, 2019 date of service, $500 for the October 25, 2019 date of service, $450 for the October 31, 2019 date of service and $450 for the November 1, 2019 date of service. The provider is not entitled to any additional reimbursement. The carrier has paid the provider 100% of what the provider has requested on her DWC-60."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2019 through November 1, 2019	CPT Code 97799-CP-GP (18 hours)	$600.00	$300.00

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 TAC §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):
    - 16-Claim/service lacks information or has submission/billing error(s).
    - 270-No allowance has been recommended for this procedure/service/supply.
    - 270-Need authorization to pay in full.
    - 320-Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 350-Bill has been identified as a request for reconsideration or appeal.
    - 375-Re-evaluation: Upon further review, an additional allowance is warranted.
    - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
    - 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 from October 7, 2019 through November 1, 2019?

Findings

1. The requestor billed for eighteen hours of chronic pain management services rendered from October 7, 2019 through November 1, 2019. The respondent wrote "The provider has been reimbursed $400 for the October 7, 2019 date of service, $500 for the October 25, 2019 date of service, $450 for the October 31, 2019 date of service and $450 for the November 1, 2019 date of service."

   Both parties submitted explanation of benefits to support the amount paid. The DWC finds for dates of service October 31 and November 1, 2019, the explanation of benefits support payment of $600.00 not $900.00; therefore, the respondent's position that payment of $900.00 was issued is not supported.

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

3. 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.

4. 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."

5. The requestor billed for 18 hours; therefore, 80% of $125.00 = $100.00 X 18 hours = $1,800.00. The respondent paid $1,500.00. As a result additional reimbursement of $300.00 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 $300.00.

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 $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/23/2020
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 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.