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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-1726-01

Carrier's Austin Representative
Box Number 01

MFDR Received Date
March 16, 2020

Response Submitted By
Liberty Mutual Insurance

REQUESTOR'S POSITION SUMMARY

"NTPRC did submit request for reconsideration of the still denied bills enclosed here. A correction was made of non-billing codes (ICD-10) … Additional denials were made… EOS's were issued which demonstrate that Liberty Mutual ignored the ICD-10 codes on the submitted requests for reconsideration… Subsequently NTPRC secured a decision at CCH under issue CO7/d that the treatment provided for the denied dates of service were related to the compensable injury… The Decision and Order issued by the Division's ALJ is the final order on extent (C07/d is categorized as an extent issue.) As stated above this request for MFDR is timely. Services performed by North Texas Pain Recovery Center were found by the Division's ALJ to be related to the compensable injury. The billing ultimately complied with Division Rules and the Labor Code."

RESPONDENT'S POSITION SUMMARY

"The bill has been reviewed and denial stands for as PLN 11: The injured employee's compensable injury is limited to… No other condition naturally resulted from or was affected by the original incident. All other injuries, conditions, diagnoses, and/or symptoms related to the injured body part or any other part of the claimant's body are denied as not resulting from the compensable injury or accident. Copy of PLNs are attached for your review."

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 22, 2019 through February 22, 2019	97799-CP-CA	$24,850.00	$17,750.00

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.

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.305 sets out the procedure for dispute resolution.
3. 28 TAC §134.230 sets out the fee guidelines for return to work rehabilitation programs.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 5593 – During a review of the submitted medical ill, a comparison was completed with the claim number noted on the medical bill and the diagnosis and service(s) performed the bill appears to be for a condition(s) which is not related to the covered work related injury or claim member noted on the bill
   - X598– Claim has been re-evaluated based on additional documentation submitted, no additional payment due

Issues

1. Are the disputed services eligible for review pursuant to 28 TAC §133.307?
2. Has the relevant extent of injury issue resolved?
3. What are the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The dispute was received by Medical Fee Dispute Resolution on March 16, 2020, and the dates of service in dispute are dated January 22, 2019 through February 22, 2019.

   Per 28 TAC 133.307 "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability."

   The DWC finds that the CCH Decision & Order was issued on March 2, 2020 and the dispute was received by MFDR on March 16, 2020, as a result the MFDR request was submitted timely and eligible for review.

2. The requestor seeks reimbursement for chronic pain management services rendered on January 22, 2019 through February 22, 2019.

   The insurance carrier states in pertinent part, "The bill has been reviewed and denial stands for as PLN 11."

   The requestor states in pertinent part, "The Decision and Order issued by the Division's ALJ is the final order on extent (C07/d is categorized as an extent issue.) As stated above this request for MFDR is timely."

   28 TAC §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 TAC §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   The services in dispute were denied, in part, due to an unresolved extent of injury issue. The issue raised and addressed in a Contested Case Hearing (CCH) on March 2, 2020 states, "Do any or all services provided by North Texas Pain Recovery Center on January 22, 2019, through February 22, 2019, related to the compensable injury?" It its decision, the DWC concluded that "All services provided by North Texas Pain Recovery Center on January 22, 2019, through February 22, 2019, relate to the compensable injury." The Carrier was ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

   Review of the Division records supports that the CCH Decision & Order was appealed and, an ALJ affirmed that the Decision & Order dated March 2, 2020 became final on May 1, 2020. The DWC concludes that the issue is resolved and therefore, the services in dispute are eligible for review by MFDR.

3. The Requestor seeks reimbursement for chronic pain management services rendered on January 22, 2019 through February 22, 2019, CPT Code 97799-CP-CA.

   28 TAC §134.230 states, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. 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 insurance 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 maximum allowable reimbursement (MAR)…

(5) 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 medical bills, document that the requestor appended modifier-CA to CPT Code 97799-CP, as a result the requestor is entitled to $125.00 per hour.

Date of service	CPT Code	# Units Billed	Amount Billed	Amount Paid	Amount Due
January 22, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
January 23, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
January 24, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
January 25, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
January 28, 2019	97799-CP-CA	5	$875.00	$0.00	5 x $125 = $625.00
January 29, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
January 30, 2019	97799-CP-CA	7	$1,225.00	$0.00	7 x 125 = $875.00
January 31, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 1, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 11,2 019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 12, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 13, 2019	97799-CP-CA	7	$1,225.00	$0.00	7 x 125 = $875.00
February 14, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 15, 2019	97799-CP-CA	7	$1,225.00	$0.00	7 x 125 = $875.00
February 18, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 19, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 20, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 21, 2019	97799-CP-CA	8	$1,400.00	$0.00	8 x $125 =$1,000.00
February 22, 2019	97799-CP-CA	4	$700.00	$0.00	4 x $125 =$500.00
TOTAL		142	$24,850.00	$0.00	$17,750.00

The DWC finds that the requestor is entitled to a total recommended amount of $17,750.00 for CPT Code 97799-CP-CA rendered on January 22, 2019 through February 22, 2019. As a result, 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 $17,750.00.

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 $17,750.00 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 8, 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.