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
PRC HEALTH SERVICES LLC

Respondent Name
AMERICAN FIRE & CASUALTY CO

MFDR Tracking Number
M4-20-2216-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 7, 2020

REQUESTOR'S POSITION SUMMARY

July 10, 2020: "we have only date of service 10/16/19 outstanding carrier owes additional $50.00."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

"The bills have been reviewed and adjusted for payments – copies of EOBs are submitted for your review."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2019	CPT Code 97799-CP-GP (6.5 hours)	$50.00	$0.00

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):
   - P12-Workers Compensation state fee schedule adjustment.
   - 4961-The hourly rate has been reduced to fifteen minute increments due to the modifier billed.
   - W3-Additional payment made on appeal/reconsideration.
   - 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 on October 16, 2019?

Findings

1. The requestor originally sought medical fee dispute resolution in the amount of $800.00 for dates of service October 7, 2019 through November 7, 2019. The respondent issued a supplemental payment for the services and only October 16, 2019 for $50.00 remains in dispute.

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

3. The submitted medical report supports the claimant participated in 6.5 hours of chronic pain management services.

4. 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.

5. 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.”

6. The requestor billed for 6.5 hours; therefore, 80% of $125.00 = $100.00 X 6.5 hours = $650.00. The respondent originally paid $600.00. On January 9, 2020, the respondent issued an additional payment of $50.00 with check reference: [redacted] therefore, the requestor was paid in full and additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/24/2020 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 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.