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
PAIN AND RECOVERY CLINIC

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-20-2364-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
MAY 22, 2020

REQUESTOR'S POSITION SUMMARY

"We obtained preauthorization according to division rules and regulations. We feel that our facility should be paid according to thee fee schedule guidelines. We are a CARF accredited facility."

Amount in Dispute: $125.00

RESPONDENT'S POSITION SUMMARY

"The provider is billing CPT code 97799 for Accredeited Chronic pain treatment. This is reimbursed at $125.00/per hour. The documentation supports the provider spent 3 hours with the ptient and therefore $375 would be the allowable amount."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2020	Chronic Pain Management Program CPT Code 97799 CP-CA (4 hours)	$125.00	$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 a medical fee dispute.
2. 28 TAC §134.230, effective July 17, 2016, sets out the reimbursement guidelines for return to work rehabilitation programs.
3. The respondent reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - B12-Services not documented in patient's medical records.
   - 18-Exact duplicate claim/service.

Issues

Is the requestor entitled to additional reimbursement of $125.00 for CPT code 97799-CP-CA rendered on March 11, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $125.00 for chronic pain management program, CPT code 97799-CP-CA, rendered on March11, 2020.
2. The respondent denied reimbursement for chronic pain management program based upon “B12-Services not documented in patient’s medical records.”
3. The fee guideline for chronic pain management services is found in 28 TAC §134.230.
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-CA; therefore, the disputed program is CARF accredited and reimbursement shall be 100% 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 4 hours. A review of the submitted Progess Notes indicates claimant underwent 90 minutes of Pain Management/Education and 90 minutes on Daily activity sheet for a total of three hours. The requestor’s documentation does not support the four hours billed. The calculation is 100% of $125.00 = $125.00 X 3 hours = $375.00. The respondent paid $375.00. As a result additional reimbursement is not 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/02/2020 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.