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
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2516-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JUNE 17, 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."

Supplemental Position submitted via email on June 26, 2020: "Good afternoon, we received a response from the carrier denying to pay our bills. I attached charts as clarification on the prior authorizations we have on file for the patient. I hope these help the carrier process our bills appropriately."

Amount in Dispute: $3,062.50 (The DWC-60 noted total amount in dispute as $3,062.20 this is a typographical error because the sum of the amount in dispute is $3,062.50)

RESPONDENT'S POSITION SUMMARY

"The bills for 03/10/2020 tp 03/16/2020 have been reviewed and denial stands as no auth was found for the Dos in question per TX Rule 134.600. On December 16, 2019, Pain & Recovery Clinic submitted a request for UM approval for 80 hours of Chronic Pain Treatment. Our Utilization Management Team approved this request…to be used from 12/16/2019 thru 02/16/2020. On February 26, 2020, the provider submitted a request for an extension the end date until 03/06/2020 which was approved…The bills for 03/10/2020 to 03/16/2020 do not fall under this UM approval and therefore no payment is due."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2020 March 11, 2020 March 13, 2020 March 16, 2020	Chronic Pain Management Program CPT Code 97799 CP-CA (24.5 hours)	$3,062.50	$3,062.50

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 §134.600, 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. The respondent reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - 5917-Pre-authorization was required, but not requested for this service per DWC rule 134.600.
   - W3-Additional payment made on appeal/reconsideration.
   - 5882-Pre-authorization was requested but denied for this service per DWC rule 134.600.

Issues

Is the requestor entitled to additional reimbursement of $3,062.50 for CPT code 97799-CP-CA rendered from March 10, 2020 through March 16, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $3,062.50 for chronic pain management program, CPT code 97799-CP-CA, rendered from March 10, 2020 through March 16, 2020.
2. The respondent denied reimbursement for chronic pain management program based upon a lack of preauthorization.
3. The requestor contends that reimbursement is due because the disputed services were preauthorized.
4. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:
   - 28 TAC §134.600(p)(10) requires preauthorization for “chronic pain management/interdisciplinary pain rehabilitation.”
   - 28 TAC §134.600(q)(5) provides for “concurrent utilization review for an extension forpreviously approved services includes: chronic pain management/interdisciplinary pain rehabilitation.”
   - 28 TAC §134.600(l)(1-2) states, “The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include: (1) the specific health care; (2) the approved number of health care treatments and specific period of time to complete the treatments.”
5. Both parties to the dispute submitted the following copies of the preauthorization reports to support their positions:
   - On December 17, 2019, Transaction Code: [redacted]-Liberty Mutual authorized 80 hours of chronic pain management services “Service Date(s): From: 12/16/2019 to 02/16/2020 for 1 day(s) or visit(s) and 10 week(s), if applicable.” The report also states, “This certification is valid for 30 days of receipt of this notification.”
   - On February 20, 2020, Transaction Code: [redacted] -Liberty Mutual authorized 40 hours of chronic pain management services. The report indicates, “Service Date(s): From: 02/18/2020 to 04/18/2020 for 5 day(s) or visit(s) and 2 week(s), if applicable.” The report also states, “This certification is valid for 30 days of receipt of this notification.”
   - On February 27, 2020, Transaction Code: [redacted]-Liberty Mutual authorized “Additional 10 days (80 hours) of chronic pain management for the cervical spine. Extended end date: 03/06/2020.”
6. The DWC finds based upon the February 20, 2020 preauthorization report, the disputed services were preauthorized; therefore, the respondent’s denial based upon a lack of preauthorization is not supported. The DWC finds the requestor is due reimbursement for the disputed services.
7. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

8. 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.

9. 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.”

10. The requestor billed for 24.5 hours; therefore, 100% of $125.00 = $125.00 X 24.5 hours = $3,062.50. The respondent paid $0.00. As a result reimbursement of $3,062.50 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 $3,062.50.

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 $3,062.50 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	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.