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

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-20-2700-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 13, 2020

Response Submitted By:
No response submitted

REQUESTOR'S POSITION SUMMARY

"1)We properly billed the DOS (5/28/20) in question and performed request for reconsideration. 2) The services in question have been approved by the carrier's utilization review department."

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Ace American Insurance Company is Downs & Stanford, PC. Downs & Stanford, PC was notified of this medical fee dispute on July 21, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 28, 2020	97799-CP-GP	$550.00	$550.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.204 sets out the sets out the fee guidelines for the workers' compensation specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider
   - * – This procedure requires prior authorization, and none was identified.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - D1 – Duplicate control number

Issue(s)

1. Did the requestor submit documentation to support that CPT Code(s) 97799-CP rendered on May 28, 2020 was preauthorized?
2. What are the rules that apply to chronic pain management reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP rendered on May 28, 2020. The insurance carrier denied the disputed charges due to lack of preauthorization.

   The requestor seeks reimbursement for a non-CARF accredited chronic pain management services, CPT Code 97799-CP.

   Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   The requestor submitted a copy of a preauthorization letter issued by MedInsight a Subsidiary of Gallagher Bassett Services, Inc., dated April 23, 202. The preauthorization letter indicates the following:

   Chronic Pain Management services, 10 units/visits DOS start April 28, 2020 and DOS end date of July 28, 2020. The services in dispute were rendered on May 28, 2020 within the preauthorized timeframe. As a result, the DWC finds that the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for the disputed service.

   Per 28 Texas Administrative Code §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   As a result, the requestor is entitled to reimbursement for the disputed services, pursuant to 28 TAC §134.204.

2. Per 28 Texas Administrative Code §134.204 (h)(1)(A-B) states in pertinent part, "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 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 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."

   Review of the submitted documentation finds that the requestor billed CPT code 97799-CP and did not appended modifier –CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement is calculated at 80% of the MAR pursuant to 28 Texas Administrative Code §134.204 (h).

   To determine reimbursement for a chronic pain management program, the division applies the following:

   28 Texas Administrative Code §134.204 (h) (1) (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.

   28Texas Administrative Code §134.204 (h) (5) (A) (B) "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."

The Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	80% MAR $125 X 80% = $100.00 (MAR)	Paid Amount	Amount Due
May 28, 2020	97799-CP	$687.50	5.5	$100 x 5.5 = $550.00	$0.00	$550.00
TOTAL		$687.50	5.5	$550.00	$0.00	$550.00

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $550.00. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $550.00.

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 $550.00 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	October 6, 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, 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 MFDR 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.