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
MILLENIUM CHIROPRACTICE & REHAB

Respondent Name
EMPLOYERS PREFERRED INSURANCE COMPANY

MFDR Tracking Number
M4-20-2829-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
July 30, 2020

Response Submitted by:
No position summary was submitted

REQUESTOR'S POSITION SUMMARY

"THESE SERVICES WERE ALL PRE-AUTHORIZED AND WERE ADMINISTERED TO A BODY PART/ CONDITION THAT WAS DEEMED COMPENSABLE BY THE CARRIER. THE CARRIER HAS ZERO BASIS FOR NON-PAYMENT. THE CARRIER NEVER SENT US EOBs FOR ANY OF THE ABOVE DATES."

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 25, 2019 through August 14, 2019	97799-CP	$2,600.00	$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.

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC 134.230 sets out the fee guidelines for chronic pain management
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - Payment recommended in the amount of $2,600.00
    - No denial reductions indicated on the EOB dated August 7, 2020

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Did the insurance carrier issue payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP rendered on, July 25, 2019 through August 14, 2019.

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

   Per 28 TAC §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 PRIUM, dated July 30, 2019. The preauthorization letter indicates the following:

Requested Procedure/Service	1 chronic pain management program (80 units) to include CPT code: 97799 (unlisted rehabilitation procedure) between 7/25/2019 and 8/24/2019.
Determination:	Recommend prospective request for 1 chronic pain management program (80 units) to include CPT code: 97799 (unlisted rehabilitation procedure)
Timeframe to provide certified procedure/service	between 7/25/2019 and 8/24/2019 be certified. 30 days

   Per 28 TAC §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. The requestor seeks a total reimbursement amount of $2,600.00. Review of the EOB dated, August 7, 2020 submitted by the insurance carrier supports that a payment in the amount of $2,600.00 was issued to the requestor for disputed dates of service July 25, 2019 through August 14, 2019 under control number: 306435746. Additional documentation was requested from the insurance carrier to further support payment of $2,600.00, and a copy of a check (Check # 27751126) dated August 12, 2020 endorsed and cashed by the requestor was provided to the DWC and the requestor. The DWC will now determine if the insurance carrier issued payment in accordance with the fee guidelines.

   Per 28 TAC §134.23- (A)(B) states in pertinent part, "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 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 reimbursed if greater than or equal to eight minutes and less than 23." Review of the submitted documentation finds that the requestor billed CPT code 97799-CP and did not append 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 TAC §134.230 (1)(B).

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

   28 TAC §134.230 (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.

   The Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	80% MAR = $100/hour	Paid Amount	Amount Due
July 25, 2019	97799-CP	$400.00	4	$100 x 4 = $400.00	$400.00	$0.00
July 26, 2019	97799-CP	$400.00	4	$100 x 4 = $400.00	$400.00	$0.00
August 12, 2019	97799-CP	$600.00	6	$100 x 6= $600.00	$600.00	$0.00
August 13, 2019	97799-CP	$600.00	6	$100 x 6= $600.00	$600.00	$0.00
August 14, 2019	97799-CP	$600.00	6	$100 x 6= $600.00	$600.00	$0.00
TOTAL		$2,600.00	26	$2,600.00	$2,600.00	$0.00

3. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the services in dispute, as a result, $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor is not entitled to additional reimbursement for the services in dispute. 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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 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 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.