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
PAIN AND RECOVERY CLINIC

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-0451-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
NOVEMBER 16, 2020

REQUESTOR'S POSITION SUMMARY

"We obtained preauthorization and billed according to division rules and regulations. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $1,456.25

RESPONDENT'S POSITION SUMMARY

"Upon receipt of the MDR requested, the bill was sent for reconsideration. The review determined that the provider is not due additional money."

DOS 9-29-20: "Upon receipt of the MDR requested, the bill was sent for reconsideration. Payment of $625.00 was issued on 12-8-2020 for DOS 9-29-20. Attached are copies of the EOR and the payment screen for bill payment issued."

DOS 9-30-20: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $375.00."

DOS 10-2-20: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $406.25."

Responses Submitted By: ESIS Bill Review

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2020 September 30, 2020 October 2, 2020	CPT Code 97799-CP-CA-GP (18 hours)	$1,456.25	$781.25

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):
   - 222-Charge exceeds fee schedule allowance.
   - 362-Modifier -GP service delivered under an outpatient physical therapy plan of care.
   - 148-This procedure on this date was previously reviewed.
   - 18-Duplicate claim/service.
   - Previous gross recommended payment amount on line: $62.50; Additional recommended allowance of $625.00 is being made based upon additional supporting documentation.
   - 437-Chronic Pain Management.
   - CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

Issues

Is the requestor entitled to additional reimbursement for chronic pain management program rendered on September 29 through October 2, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,456.25 for chronic pain management program rendered September 29 through October 2, 2020.

2. Upon receipt of this MDR, the respondent issued an additional reimbursement of $625.00 for DOS September 29, 2020. As stated above, the respondent maintained the denial of payment for DOS September 30 and October 2, 2020.

3. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

4. 28 TAC §134.230(1)(A) 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."

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."

   The requestor billed 97799-CP-CA-GP; therefore, the disputed program is CARF accredited and reimbursement shall be 100% of the MAR.

   The requestor billed for a total of 18 hours on the disputed dates of service; therefore, 100% of $125.00 = $125.00 X 18 hours = $2,250.00. The respondent paid $1,468.75. The requestor is due the difference of $781.25

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 $781.25.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $781.25 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/14/2020
Signature	Medical Fee Dispute Resolution Officer	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.