MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENNIUM CHIROPRACTIC

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-21-0453-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
NOVEMBER 17, 2020

REQUESTOR'S POSITION SUMMARY

"ALL of these disputed DOS are PRE-AUTHORIZED services, approved by the insurance carrier and according the ODG guides, and MUST BE PAID."

Amount in Dispute: $3,000.00

RESPONDENT'S POSITION SUMMARY

"The Carrier paid the medical bills in dispute per the attached EOBs. Interest in the amount of $82.48 is being issued today."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2019	CPT Code 97799-CP-GP (6 hours)	$600.00	Not eligible for review
November 14, 2019 November 22, 2019 November 25, 2019 November 26, 2019	CPT Code 97799-CP-GP (6 hours per day)	$2,400.00	$0.00
Total		$3,000.00	$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 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):
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 948-Re-reviewed at providers request with additional information and documentation additional payment suggested.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this

claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for chronic pain management program rendered from November 13, 2019 through November 26, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $3,000.00 for chronic pain management program rendered from November 13, 2019 through November 26, 2019.

2. 28 TAC §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the DWC's MFDR Section or waive the right to MFDR. The DWC shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The DWC reviewed the submitted documentation and finds:

   - The request for medical dispute resolution was received in MFDR on November 17, 2020.
   - The disputed dates of service are November 13, 2019 through November 26, 2019.
   - The disputed services do not involve issues identified in §133.307(c)(1)(B).
   - Date of service November 13, 2019 is past the one year deadline.
   - Because the requestor did not file this dispute with MFDR within the one year deadline, this date of service it is not eligible for MFDR.
   - The respondent issued payment of $600.00 for this date of service.

3. The respondent issued payment of $3,000.00 for the disputed chronic pain management program based upon the fee guideline.

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

5. 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-GP; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

6. 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.”

7. As stated above, only dates of service November 14 through November 26, 2019 are eligible for medical fee dispute resolution. The requestor billed for six hours per day for a total of 24 hours; therefore, 80% of $125.00 = $100.00 X 24 hours = $2,400.00. The respondent paid $2,400.00. 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 $00.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/28/2021 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.