TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Texas Pain Recovery Center

Respondent Name
Zurich American Insurance Co.

MFDR Tracking Number
M4-21-2252-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 9, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 13, 2020	CPT Code 97799-CP-CA (X8)	$1,400.00	$1,000.00
	Total	$1,400.00	$1,000.00

Requestor's Position

"It is the position of NTPRC that the carrier did change the CPT code in question. The denial reasons show that the date was previously billed by way of denial reason 72. Each of the other days billed for the same service was paid properly."

Email dated October 20, 2021: "There is over one year of interest due. Interest is not optional and the carrier willfully delayed these payments."

Amount in Dispute: $1,400.00

Respondent's Position

"The Respondent disputes the accuracy of the Requestor's billing and denies the Requester is

entitled to the amount claimed for the services rendered…The therapy provided was not a chronic pain program. It is merely work hardening."

Response Submitted by: Stephen J. Backhaus

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.230 sets out the reimbursement guidelines for return-to-work rehabilitation programs.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 223-Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
- 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 10-The diagnosis is inconsistent with the patient's gender.

Issues

1. Is Zurich American Insurance Company's denial based on the modifier is inconsistent with the service rendered supported?

2. Is North Texas Pain Recovery Center entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,400.00 for chronic pain management program rendered on August 13, 2020.

   The respondent denied reimbursement for the disputed chronic pain management program based upon reason code "4-The procedure code is inconsistent with the modifier used or a required modifier is missing." The respondent wrote, "The therapy provided was not a chronic pain program. It is merely work hardening."

The DWC reviewed the submitted Weekly Progress Report that supports an interdisciplinary program that focuses on physical therapy, psychosocial, and pain management services. The DWC finds the respondent's denial based upon reason code "4" is not supported.

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

3. 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."

4. 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; 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 8 hours = $1,000.00. The respondent paid $00.00. The requestor is due the difference of $1,000.00

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement of $1,000.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Zurich American Insurance Co. must remit to North Texas Pain Recovery Center $1,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/22/2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.