TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PAIN & RECOVERY CLINIC

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-22-0011-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 2, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2021 through July 19, 2021	97799-GP-CP-CA	$18,750.00	$18,750.00
	Total	$18,750.00	$18,750.00

Requestor's Position

"We obtained preauthorization according to division rules and regulations. We feel that our facility should be paid according to the fee schedule guidelines. We arc a CARF accredited facility and should not be subject to the twenty percent fee schedule reduction. I have provided the letter of certification as proof."

Amount in Dispute: $18,750.00

Requestor's Supplemental Position

"A waiver should apply to newly addressed extent of injury issue, and it is our belief the medical dispute resolution review should be processed based on the original and provided denials."

Respondent's Position

"A review of the services provided indicate that the treatment greatly exceeded medical treatment for… In those cases, in which the provider has identified the ICD-I0 diagnosis code, the extent of injury defense is not available to the carrier, but the relatedness defense is available."

Response Submitted by: Flahive, Ogden & Latson

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 Texas Administrative Code (TAC) §133.307 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. 28 TAC §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reasons

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

- 5225 – Services denied at the time authorization/pre-certification was requested
- 309 – Charges for this procedure exceeds the fee schedule allowance.
- TC P12 & P12 – Workers Compensation jurisdictional fee schedule adjustment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Did the insurance carrier raise a new issue after the filing of the MDR?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $18,750.00 for chronic pain management program rendered from June 14, 2021 through July 19, 2021.

   In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that "A review of the services provided indicate that the treatment greatly exceeded medical treatment for… The Medical Review Division has recognized lack of relatedness disputes in cases in which a provider has identified a diagnosis code accepted by the carrier when the medical treatment itself indicates that the treatment is for something other than the accepted condition."

   The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review. The submitted documentation does not support that a denial based on relatedness was provided to the requestor before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. The insurance carrier denied CPT Code 97799-CP-CA with denial reduction code 5225 (description provided above.)

   28 Texas Administrative Code §134.600 (p) states, "non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation…"

   Review of the submitted documentation supports that the requestor obtained preauthorization for CPT Code 97799-CP-CA. The requestor obtained preauthorization from Coventry, on June 11, 2021. The preauthorization letter indicates the following:

   "On behalf of Cottingham & Butler, the requested treatment referenced above has been reviewed by Coventry Health Care Workers' Compensation, Inc.(Coventry), and has been determined to be medically necessary."

   The preauthorization letter preauthorized Chronic Pain Management Program x 80 hours 97799 with a start date of 6/11/21 and an end date of 8/11/21.

   The requestor obtained a secondary preauthorization from Coventry on July 6, 2021. The preauthorization letter preauthorized Chronic Pain Management Program x 80 hours 97799 with a start date of 7/6/21 and an end date of 9/4/21.

   The requestor seeks reimbursement for dates of service June 14, 2021 through July 19, 2021. The DWC finds that the services in dispute were rendered within the preauthorized timeframes. 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 services in dispute.

   28 Texas Administrative Code §134.600 (c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

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

   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)…"

   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 unit's 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.

Review of the submitted documentation finds that the requestor billed CPT Code 97799-CP and appended modifier –CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement is calculated per 28 TAC §134.230(1)(A) and 28 TAC §134.230(5)(A)-(B).

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $125/hour	Amount Due
6/14/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/15/21	97799-CP-CA	6.5	$812.50	$0.00	$812.50	$812.50
6/16/21	97799-CP-CA	6.5	$812.50	$0.00	$812.50	$812.50
6/17/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/18/21	97799-CP-CA	6.5	$812.50	$0.00	$812.50	$812.50
6/21/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/22/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/23/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/24/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/28/21	97799-CP-CA	5.5	$687.50	$0.00	$687.50	$687.50
6/29/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
6/30/21	97799-CP-CA	5	$625.00	$0.00	$625.00	$625.00
7/7/21	97799-CP-CA	7	$875.00	$0.00	$875.00	$875.00
7/8/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/9/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/12/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/13/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/14/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/15/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/16/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
7/19/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
TOTALS			$18,750.00	$0.00	$18,750.00	$18,750.00

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 $18,750.00 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 the Respondent must remit to the Requestor $18,750.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 2, 2021
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 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.