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
NORTH TEXAS PAIN RECOVERY

Respondent Name
DALLAS AREA RAPID TRANSIT

MFDR Tracking Number
M4-22-0170-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
September 27, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 19, 2020 through October 23, 2020	97799-CP-CA	$5,000.00	$5,000.00
	Total	$5,000.00	$5,000.00

Requestor's Position

"This claim was originally sent to Sedgwick, processed on 07/27/2021 and denied due to 'amount adjusted is due to bundling or unbundling of services.' Psychological testing and scoring is a(n) E/M Service, all performed on the same day. Code 97799 is an additional needed hour for testing, therefore, cannot be denied as a different (bundled nor unbundled) service from cpt code 9799[sic]."

Amount in Dispute: $5,000.00

Respondent's Position

The Austin carrier representative for Dallas Area Rapid Transit is Hoffman Kelley LLP. Hoffman Kelley LLP was notified of this medical fee dispute on October 5, 2021. 28 TAC §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 fee guidelines for return-to-work rehabilitation programs.

Denial Reasons

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

- 5189 – RECONSIDERATION REQUESTS REQUIRE A DISPUTE LETTER, ITEMIZED BILLING, AND MEDICAL RECORDS FOR FURTHER REVIEW, PLEASE SUBMIT YOUR RECONSIDERATION REQUEST WITH THE REQUIRED DOCUMENTATION.
- 5343 – PLEASE NOTE THIS IS A RECONSIDERATION FOR A PRIOR REVIEW.
- 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESED PROPERLY.
- N706 – MISSING DOCUMENTATION

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement for CPT Code 97799-CP-CA rendered on October 19, 2020 through October 23, 2020, CPT Code 97799-CP-CA. The insurance carrier denied the services in dispute with reduction codes, 5189, 5343, 16, 193 and N706 (description provided above.)

   The insurance carrier did not respond to the MDR request. The DWC finds that the insurance carrier did not submit documentation to support the denial reasons indicated above. As a result, the requestor is entitled to reimbursement for the services in dispute.

2. 28 TAC §134.230 states, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division, Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.

(1) 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)…

(5) 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."

Review of the medical bills, document that the requestor appended modifier-CA to CPT Code 97799-CP, as a result the requestor is entitled to $125.00 per hour.

DOS	CPT Code	# units	Amt Billed	Amt Paid	MAR-CARF $125/hour	Amt Due
10/19/20	97799-CP-CA	8	$1,400.00	$0.00	$125 x 8 hrs. = $1,000.00	$1,000.00
10/20/20	97799-CP-CA	8	$1,400.00	$0.00	$125 x 8 hrs. = $1,000.00	$1,000.00
10/21/20	97799-CP-CA	8	$1,400.00	$0.00	$125 x 8 hrs. = $1,000.00	$1,000.00
10/22/20	97799-CP-CA	8	$1,400.00	$0.00	$125 x 8 hrs. = $1,000.00	$1,000.00
10/23/20	97799-CP-CA	8	$1,400.00	$0.00	$125 x 8 hrs. = $1,000.00	$1,000.00
TOTALS		40	$7,000.00	$0.00	$5,000.00	$5,000.00

3. The DWC finds that the requestor is entitled to a total recommended amount of $5,000.00 for CPT Code 97799-CP-CA rendered on October 19, 2020 through October 23, 2020. As a result, this amount is recommended.

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.

The DWC finds the requester has established that reimbursement of $5,000.00 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 the Respondent must remit to the Requestor $5,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 6, 2022
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.