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 Center

Respondent Name
Hartford Casualty Insurance Co.

MFDR Tracking Number
M4-22-0183-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 24, 2020	CPT Code 97799-CP-CA (X6)	$1,400.00	$625.00
	Total	$1,400.00	$625.00

Requestor's Position

"It is NOT IMPOSSIBLE for the carrier to simply read the rules and understand that two separate authorization numbers require two separate bills."

October 22, 2021: "The carrier is not entitled to a refund but rather it owes full payment of the medical bills in question."

Amount in Dispute: $1,400.00

Respondent's Position

October 15, 2021: "The carrier is reprocessing the provider's bill. However, the provider is certainly not entitled to reimbursement of $175 per hour…the amount requested ($1,400) is more than the provider billed for that date of service."

October 20, 2021: "the provider's DWC 60 is confusing. The DWC-60 identifies one date of service as November 24, 2020, yet the provider has attached two CMS-1500s. One is for dates of

service November 23, 2020 and November 24, 2020 in the amount of $1,225. A second one covers dates of service November 24, 2020 and November 25, 2020 in the amount of $1,400. We are attaching a copy of the carrier's EORs and payment for these two CMS-1500s."

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

2. 28 TAC 134.230 sets out the fee guidelines for chronic pain management services.

Denial Reasons

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

- P12-Workers' compensation jurisdictional fee schedule adjustments.
- 223-Adjusted code for mandated federal, state or local law regulation…
- 00663-Reimbursement has been calculated according to state fee schedule guidelines.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247-A payment or denial has already been recommended for this service.
- 00563, 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is North Texas Pain Recovery Center entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,400.00 for chronic pain management program rendered November 24, 2020.

   The respondent paid $125.00 for the disputed chronic pain management program based upon the fee guideline.

   The requestor contends that reimbursement is due because the disputed chronic pain management program was preauthorized. In support of their position, the requestor

submitted a copy of a preauthorization report from Medinsights authorizing 80 hours of chronic pain management program.

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). (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."

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 6 hours on the disputed date of service; therefore, 100% of $125.00 = $125.00 X 6 hours = $750.00. The respondent paid $125.00. The requestor is due the difference of $625.00

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 additional reimbursement of $625.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services. It is ordered that Hartford Casualty Insurance Co. must remit to North Texas Pain Recovery Center $625.00 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	11/02/2021 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.