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

General Information

Requestor Name
NORTH TEXAS PAIN & RECOVERY

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-22-0404-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
October 29, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2020 through January 28, 2021	90791 and 97799-GP-CP-CA	$23,713.02	$16,750.00
	Total	$23,713.02	$16,750.00

Requestor's Position

"The claimant never exceeded his approved hours nor did the bills reflect more than 80 hours for each of the two UR approvals. I have enclosed the carrier's EOB's which show that the only denial still to be determined is the denial for the authorization number missing or not applicable to the service rendered."

Amount in Dispute: $23,713.02

Requestor's Supplemental Position

"Carrier made no denials for an improper referral at any time in writing. (See EOB's) All denials were based on a missing or improper authorization number on the CMS 1500 bill as demonstrated by the carrier's EOB's. Secondly Dr. Addison IS NOT THE TREATING DOCTOR of record. If so the carrier should demonstrate when the approval was given for a change of treating doctor or the Division should have an approved DWC053 change of treating doctor request… The specialist knows the type of rehabilitation the surgeon is requesting. This type of rehabilitation is typically out of the purview for the general practitioner. Referring back to a general practitioner might be a good business relationship for the general practitioner but makes little sense for the patient."

Respondent's Position

"The Provider contends they are entitled to reimbursement on the basis that the services lacked the preauthorization approval code… The Claimant was referred to the Provider for the chronic pain management program by Dr. Peter Grays, as documented on the HCFA-1500s. Dr. Grays is the surgeon to whom the Claimant was referred for a hernia repair by the Treating Doctor, Dr. Candace Addison. Attached you will find the DWC-69 completed by Dr. Addison noting her role as the Treating Doctor... As stated on the Carrier's Explanation of Benefits, denial reason 5631, this provider is not authorized to bill for this procedure/service, as the Provider was not approved or referred by the Treating Doctor."

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:

- NTWK – Priced using Coventry owned contract.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 877 – Reimbursement is based on the contracted amount.
- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers Compensation jurisdictional fee schedule adjustment.
- 5631 – The provider is not authorized to bill for this procedure/service.

Issues

1. Did the insurance carrier raise a new issue after the filing of the MDR?
2. Does the dispute contain network issues?
3. Is the requestor is entitled to reimbursement for CPT Code 90791?
4. Is the Insurance Carrier's denial reason supported?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $23,713.02 for a CARF accredited chronic pain management program rendered November 18, 2020 through January 28, 2021.

   The insurance carrier in its position statement argued "As stated on the Carrier's Explanation of Benefits, denial reason 5631, this provider is not authorized to bill for this procedure/ service, as the Provider was not approved or referred by the Treating Doctor."

   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 not approved or referred by the treating doctor 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 requestor is seeking medical fee dispute resolution in the amount of $23,713.02 for a CARF accredited chronic pain management program rendered November 18, 2020 through January 28, 2021.

   The insurance carrier denied CPT Code 97799-CP-CA with denial reduction codes NTWK , 45, 877 and 5631 (description provided above.

   The insurance carrier states in pertinent part, "The Provider chose to pursue dispute resolution with regards to the Claimant's in network status. The Division held a Contested Case Hearing, wherein the Administrative Law Judge determined the Claimant had not been properly notified of the HCN requirements. Consequently, the ALJ held the claim was not enrolled in the Carrier's HCN. As a result, only the second basis for the Carrier's denial of reimbursement remains."

   The DWC reviewed the CCH Decision & Order which indicates that the injured employee was not properly notified of the HCN requirements and found that the claim was not enrolled in the Carrier's HCN. As a result, the insurance carrier's denial reasons are not supported and the services in dispute are reviewed pursuant to the applicable rules and guidelines.

3. The requestor seeks reimbursement for CPT Code 90791 rendered on November 18, 2020.

   Per 28 TAC 133.307 (c)(2)(J) and (K) states, "(c) Requests. Requests for MFDR must be legible and filed in the form and manner prescribed by the division… (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include… (J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills); (K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health

care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB…"

The requestor did not submit a copy of a medical bill and EOBs with the DWC060 request. As a result, CPT Code 90791 rendered on November 18, 2020 is not eligible for MFDR review.

4. The requestor is seeking medical fee dispute resolution in the amount of $23,713.02 for a CARF accredited chronic pain management program rendered November 18, 2020 through January 28, 2021.

   The insurance carrier denied CPT Code 97799-CP-CA with denial reduction codes "15, 309 and P12" (descriptions 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 Travelers, on December 18, 2020. The preauthorization letter indicates the following:

   "Request: 80 hours of pain management program… The proposed date of service: 12/18/20 – 1/28/2-… UR Number 4515475.

   The requestor obtained a second preauthorization from Travelers, dated January 12, 2021. The preauthorization letter indicates the following:

   "Request: 80 additional hours of chronic pain management… Proposed dates of service are: 1/14/2021 – 2/14/2021… UR Number 4543110.

   The requestor seeks reimbursement for dates of service December 29, 2020 through January 28, 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..."

5. 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
12/28/20	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
12/29/20	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
12/30/20	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
12/31/20	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/4/21	97799-CP-CA	5	$875.00	$0.00	$625.00	$625.00
1/5/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/6/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/7/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/8/21	97799-CP-CA	1	$175.00	$0.00	$125.00	$125.00
1/14/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/15/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/18/21	97799-CP-CA	6	$1,050.00	$0.00	$750.00	$750.00
1/19/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/20/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/22/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/25/21	97799-CP-CA	6	$1,050.00	$0.00	$750.00	$750.00
1/26/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/27/21	97799-CP-CA	8	$1,400.00	$0.00	$1000.00	$1000.00
1/28/21	97799-CP-CA	4	$700.00	$0.00	$500.00	$500.00
TOTALS			$23,713.02	$0.00	$16,750.00	$16,750.00

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 $16,750.00 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 $16,750.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 1, 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.