



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

PRIDE

**Respondent Name**

INTREPID INSURANCE COMPANY

**MFDR Tracking Number**

M4-22-0946-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

January 20, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 31, 2021 through June 4, 2021	97799-CP-CA-GP-GO	\$11,360.00	\$8,875.00
<b>Total</b>		<b>\$11,360.00</b>	<b>\$8,875.00</b>

### Requestor's Position

"A Health Care Provider has met the burden of proof that the Carrier has received the claim with a certified green mail card, electronic submission, and/or a facsimile transmission report to the Carrier. Enclosed is a facsimile transmittal that shows the Carrier received this bill in a timely manner. Please re-submit this claim for payment, this claim was not filed after the 95th day."

**Amount in Dispute:** \$11,360.00

### Respondent's Position

"We will provided [sic] a supplemental response once the bill auditing company has finalized their review."

**Response Submitted by:** Gallagher Bassett

## 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, 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.
4. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
5. 28 TAC §102.4 sets out the rules for non-Commission communications.
6. TLC §408.027 sets out the rules for timely submission of claims by health care providers.
7. TLC §408.0272 provides for certain exceptions to untimely submission of a medical bill

### Denial Reasons

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

- 00060 & 29 – The time limit for filing has expired.
- P12 – Workers' compensation jurisdiction fee schedule adjustment.
- 309 – Charges for this procedure exceeds the fee schedule allowance.

### Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

### Findings

1. The requestor seeks medical fee dispute resolution in the amount of \$11,360.00 for a CARF accredited chronic pain management program rendered from March 31, 2021 through June 4, 2021. The insurance carrier denied the medical service, due to 95-day timely filing issues.

28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in TLC §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not-later than 95 days after the date the disputed services were provided.

TLC §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 TAC §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

Review of the submitted information finds sufficient documentation to support that the medical bills were submitted within 95 days from the date the services were provided. Therefore, the requestor is entitled to reimbursement for the services in dispute.

2. The insurance carrier denied CPT Code 97799-CP-CA.

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

The requestor submitted two preauthorization letters issued by Sedgwick. The preauthorization letters indicate the following:

Preauthorization letter issued by Sedgwick, dated March 9, 2021 documents the following; "Functional restoration program (80 hours) 97799, Certified." The preauthorization letter further states, "... Sedgwick has made the following decision that the services below are medically necessary or appropriate. This means we approve the services or treatment... Services approved from 3/9/2021 – 6/30/2021."

Preauthorization letter issued by Sedgwick, dated May 4, 2021, documents the following; "Functional restoration program (80 hours) 97799, Certified." The preauthorization letter further states, "... Sedgwick has made the following decision that the services below are medically necessary or appropriate. This means we approve the services or treatment... Services approved from 4/23/2021 – 6/30/2021."

The requestor seeks reimbursement for dates of service March 31, 2021 through June 4, 2021. The DWC finds that the services in dispute were rendered within the preauthorized timeframes. As a result, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for the services in dispute.

28 TAC §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
3/31/21	97799-CP-CA	4.5	\$720.00	\$0.00	\$562.50	\$562.50
4/1/21	97799-CP-CA	7.5	\$1,200.00	\$0.00	\$937.50	\$937.50
4/12/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
4/13/21	97799-CP-CA	8	\$1,280.00	\$0.00	\$1,000.00	\$1,000.00
4/16/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/6/21	97799-CP-CA	4	\$640.00	\$0.00	\$562.50	\$562.50
5/11/21	97799-CP-CA	2.5	\$400.00	\$0.00	\$312.50	\$312.50
5/13/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/14/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/17/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/18/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/21/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/24/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
5/27/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
6/1/21	97799-CP-CA	4.5	\$720.00	\$0.00	\$562.50	\$562.50
6/4/21	97799-CP-CA	4	\$640.00	\$0.00	\$500.00	\$500.00
TOTALS		71	\$11,360.00	\$0.00	\$8,875.00	\$8,875.00

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.

The DWC finds the requester has established that reimbursement of \$8,875.00 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 \$8,875.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

		May 27, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).