



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Texas Pain Recovery Center

Respondent Name

Sompo America Insurance Company

MFDR Tracking Number

M4-22-1158-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

February 15, 2022

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|---------------------------|-------------------|------------|
| December 6, 2021 | CPT Code 97799-CP-CA (X5) | \$625.00 | \$625.00 |
| Total | | \$625.00 | \$625.00 |

Requestor's Position

"We obtained preauthorization according to division rules and regulations. There was an extension granted on the end date of service per the utilization department and I attached a chart table to assist with any confusion of occurrences."

March 10, 2022 email from Anna Hernandez: "I am now attaching the original precertification letter..."

Respondent's Position

"At this time, the carrier position remains as identified in it's EOBs."

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 §134.600 requires preauthorization for chronic pain management programs.
3. 28 TAC §134.230 sets out the reimbursement 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:

- 197-Payment denied/reduced for absence of precertification/authorization.
- 199- Number of services exceed utilization agreement.
- 193, 90563-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Sompco America Insurance Company's denial based on a lack of preauthorization supported?
2. Is Pain & Recovery Clinic of North Houston due reimbursement for chronic pain management rendered on December 6, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$625.00 for chronic pain management program rendered on December 6, 2021.

The respondent denied reimbursement for the disputed chronic pain management program based upon a lack of preauthorization.

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

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 Coventry dated December 7, 2021 authorizing 40 hours of chronic pain management program starting October 6, 2021 through January 31, 2022. The requestor submitted a chart for services rendered from October 13, 2021 through January 20, 2022 to support the preauthorization was not exceeded. The DWC finds the respondent did not support denial based upon a lack of preauthorization; therefore, reimbursement is recommended.

2. 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-GP; therefore, the disputed program is CARF accredited and reimbursement shall be 100% of the MAR.

The requestor billed for a total of 5 hours on the disputed dates of service; therefore, 100% of \$125.00 = \$125.00 X 5 hours = \$625.00. The respondent paid \$00.00. 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 entitled to additional reimbursement for the disputed services. It is ordered that Sompco America Insurance Co. must remit to Pain & Recovery Clinic of North Houston \$625.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

| | | |
|-----------|--|------------|
| _____ | _____ | 03/21/2022 |
| 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 electrónico CompConnection@tdi.texas.gov.