



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PAIN & RECOVERY CLINIC

Respondent Name

SOMPO AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-22-1436-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

March 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 6, 2022 and January 11, 2022	97799-GP-CP-CA	\$1,375.00	\$1,375.00
Total		\$1,375.00	\$1,375.00

Requestor's Position

"Our facility has been having difficulties with the above carrier in processing our bills according to absence of precertification/authorization... We obtained preauthorization according to division rules and regulations. I attached the original letter certified on October 6, 2021. There was an extension granted on December 7, 2021 for end date of service per the utilization department."

Amount in Dispute: \$1,375.00

Respondent's Position

The Austin carrier representative for Sompo American Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on March 22, 2022. Rule §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 28 TAC §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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230 sets out the 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:

- 197 – Payment denied/reduced for absence of precertification/authorization.
- Note: Number of services exceed utilization agreement.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Note: Additional allowance is not recommended as the bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.

Issues

1. Did the insurance carrier respond to the DWC060 request?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement in the amount of \$1,375.00 for CPT Code 97799-CP-CA-GP rendered on January 6, 2022 and January 11, 2022.

The insurance carrier did not submit a response the DWC060 request. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The insurance carrier denied CPT Code 97799-CP-CA with denial reduction code 5225 (description 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. The preauthorization was issued by Coventry on October 6, 2021 authorizing 40 hours of 97799 with a start day of October 6, 2021 and an end date of December 6, 2021. The requestor obtained an extension on December 7, 2021 authorizing the end date of January 31, 2022.

The DWC finds that dates of service January 6, 2022, and January 11, 2022 were rendered within the preauthorized timeframes. The insurance carrier did not submit documentation to the contrary. As a result, the requestor is entitled to reimbursement for CPT Code 97799-CP-CA-GP.

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..."

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 - CARF \$125/hour	Amount Due
1/6/22	97799-CP-CA	5	\$625.00	\$0.00	\$625.00	\$625.00
1/11/22	97799-CP-CA	6	\$750.00	\$0.00	\$750.00	\$750.00
TOTALS		11	\$1,375.00	\$0.00	\$1,375.00	\$1,375.00

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 \$1,375.00 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 \$1,375.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	June 13, 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.