TDI Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PAIN & RECOVERY CLINIC

Respondent Name
SOMPO AMERICA INSURANCE COMPANY

MFDR Tracking Number
M4-22-1485-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 13, 2022 and January 20, 2022	97799-GP-CP-CA	$1,312.50	$1,312.50
	Total	$1,312.50	$1,312.50

Requestor's Position

"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. I also attached a chart table to assist with any confusion on the number of occurrences. We feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: $1,312.50

Respondent's Position

"The carrier will file a supplemental response. However, as it currently stands, the provider's DWC-60 packet includes the carrier's EORs dated February 7, 2022 and March 8, 2022. The carrier's position remains the same as identified on the EORs. However, the carrier is re-reviewing the provider's bills and will be filing a supplemental response that takes into consideration all of the facts."

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:

- 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 the claim was processed properly.

Issues

1. Did the insurance carrier submit a supplemental response?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for chronic pain management services rendered on January 13, 2022 and January 20, 2022. The insurance carrier in the response to the DWC060 requests dated April 11, 2022, states in relevant part, "The carrier will file a supplemental response. However, as it currently stands, the provider's DWC-60 packet includes the carrier's EORs dated February 7, 2022 and March 8, 2022."

   The DWC finds that the insurance carrier has not submitted a supplemental response as of the date of this audit. As a result, the disputed services are reviewed with the documentation contained in the dispute at the time of the review.

2. The insurance carrier denied CPT Code 97799-CP-CA due to lack of preauthorization and number of services exceed utilization agreement.

   28 TAC §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 Coventry, on October 6, 2021. The preauthorization letter indicates the following:

"On behalf of GALLAGHER BASSETT, the requested treatment referenced above has been reviewed by Coventry Health Care Workers Compensation, Inc. (Coventry) and has been determined to be medically necessary."

The preauthorization letter preauthorized Chronic Pain Management Program x 40 hours 97799 with a start date of 10/6/21 and an end date of 12/6/21.

The requestor obtained a secondary preauthorization from Coventry dated December 7, 2021. The preauthorization letter preauthorized Chronic Pain Management Program x 40 hours 97799 with a start date of 10/6/21 and an end date of 1/31/22.

The requestor seeks reimbursement for dates of service January 13, 2022 and January 20, 2022. 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..."

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
01/13/22	97799-CP-CA	5.5	$687.50	$0.00	$687.50	$687.50
01/20/22	97799-CP-CA	5	$625.00	$0.00	$625.00	$625.00
TOTALS			$1,312.50	$0.00	$1,312.50	$1,312.50

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 $1,312.50 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 $1,312.50 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	June 22, 2022 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.