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

General Information

Requestor Name
CHRONIC PAIN RECOVERY CENTER

Respondent Name
XL INSURANCE AMERICA

MFDR Tracking Number
M4-22-1743-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 19, 2021 through October 22, 2021	97799-GP-CP-CA	$4,000.00	$4,000.00
	Total	$4,000.00	$4,000.00

Requestor's Position

"The charges referenced herein were filed with the Carrier and denied for services not documented in patient's medical records. Request for reconsideration has been denied also."

Amount in Dispute: $4,000.00

Respondent's Position

The Austin carrier representative for XL Insurance America Inc., Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on April 19, 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 §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, 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:

- 309 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 5347 CV: Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.
- B12 SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
- P12 WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 247 A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
- 813 PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Did the requestor obtain preauthorization for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $4,000.00 for chronic pain management services rendered October 19, 2021 through October 22, 2021.

   The insurance carrier denied CPT Code 97799-CP-CA with denial reduction code 5347 and B12 (description provided above.)

   The insurance carrier did not respond to the DWC060 request. As a result, the dispute will issue a decision based on the information contained in the dispute. Review of the medical documentation supports that the requestor billed and documented a chronic pain management program.

   The DWC finds that the insurance carrier's denial reasons are not supported. As a result, the services in dispute are reviewed pursuant to the applicable rules and guidelines.

2. 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 Coventry, on August 23, 2021. The preauthorization letter indicates the following:

   "On behalf of CVS-SEDGWICK, 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 80 hours 97799 with a start date of 08/23/21 and an end date of 11/30/21.

   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..."

   The DWC finds that the services in dispute were rendered within the preauthorized timeframes, as a result, the requestor is entitled to reimbursement.

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."

   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 shall be 100% of the MAR.

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $125/hour	Amount Due
10/19/21	97799-CP-CA	8	$1,000.00	$0.00	$1,000.00	$1,000.00
10/20/21	97799-CP-CA	8	$1,000.00	$0.00	$1,000.00	$1,000.00
10/21/21	97799-CP-CA	8	$1,000.00	$0.00	$1,000.00	$1,000.00
10/22/21	97799-CP-CA	8	$1,000.00	$0.00	$1,000.00	$1,000.00
TOTALS			$4,000.00	$0.00	$4,000.00	$4,000.00

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 $4,000.00 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 $4,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 22, 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 electronico CompConnection@tdi.texas.gov.