TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PAIN & RECOVERY CLINIC

Respondent Name
MIDWEST INSURANCE COMPANY

MFDR Tracking Number
M4-22-2106-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 26, 2022 and January 31, 2022	97799-CP-CA-GP	$687.50	$687.50
	Total	$687.50	$687.50

Requestor's Position

"After requesting reconsideration in a timely fashion VIA mail, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. We obtained preauthorization according to division rules and regulations. We feel that our facility should be paid according to the fee schedule guidelines of a CARF accredited facility. The Provider attached some of the Carrier's EOBs/EORs. The Carrier stands by its original position."

Amount in Dispute: $687.50

Respondent's Position

"The Provider billed for a Chronic Pain Management Program. The Provider billed $750 for each of the dates of service. The Provider acknowledged that it had been reimbursed for some of the services but had not been fully reimbursed. The Provider is seeking additional reimbursement of $375 for the January 26, 2022 date of service and $312.50 for the January 31, 2022 date of service."

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:

- 224 – Duplicate charge.
- 18 – Exact duplicate claim/service.

Issues

1. Are the Insurance Carrier's denial reasons supported?
2. Did the requestor obtain preauthorization for the chronic pain management services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for chronic pain management services rendered on January 26, 2022 and January 31, 2022. The insurance carrier denied/reduced the services in dispute with reduction codes 224 and 18 (description provided above.)

   Review of the documentation contained in the dispute finds that there is no documentation to support that the disputed services are duplicate charges. The insurance carrier issued partial payments to the requestor for date of service January 26, 2022 and January 31, 2022. The DWC therefore finds, that the requestor is entitled to additional reimbursement for the services in dispute.

2. 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 chronic pain management program. The preauthorization was issued by Rising, Utilization Review, and is dated December 29, 2021. The preauthorization letter indicates the following:

   "Utilization Review has been requested on the treatment referenced below. After review of the medical information submitted at this time, the following services are certified as

medically necessary and appropriate."

The preauthorization letter preauthorized an additional 40 hours of a Chronic Pain Management Program with a start date of "To Be Scheduled."

The requestor seeks reimbursement for dates of service January 26, 2022 and January 31, 2022. The DWC finds that the services in dispute were rendered within the preauthorized timeframes. As a result, 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 Billed	IC Paid	Amount in Dispute	MAR $125/hour	Amount Due
1/26/22	97799-CP-CA	6	$750.00	$375.00	$375.00	$750.00	$375.00
1/31/22	97799-CP-CA	6	$750.00	$437.50	$312.50	$750.00	$312.50
TOTALS			$1,500.00	$812.50	$687.50	$1,500.00	$687.50

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 additional reimbursement of $687.50 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $687.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 7, 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.