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
PATIENTS CHOICE FAMILY MEDICINE

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-22-2167-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
June 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 2, 2021 through December 14, 2021	97799-CP	$26,860.00	$6,800.00
	Total	$26,860.00	$6,800.00

Requestor's Position

"I have received an EOB denial for the above dates of service stating **"197-PA YMENT DENIED/ REDUCED FOR ABSENCE OF PRECERTIFICATIN/AUTHORIZATION. 199- NUMBER OF SERVICES EXCEED UTILIZATION AGREEMENT."** Our office feels this is an invalid denial due to the fact that CPT code (97799) Functional Restoration Program was pre-authorized, the pre-authorization# is 4958378 the Pre-authorization is for 80 hrs... We have made every attempt to get our claims paid with no success. At this time, I am forwarding all my claims to MDR."

Amount in Dispute: $26,860.00

Respondent's Position

"The Division placed a copy of the DWC060 in the insurance carrier's Austin representative box, which was acknowledged received on June 7, 2022. Per 28 TAC §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

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:

- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SBMIT A COPY OF THIS EOR OR CLEAR NOTATION.
- 90563 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROESSED PROPERLY.
- 90950 - THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS REFLECT ANY CHANGES TO THE PREVIOUS PAYMENT.
- 197 - PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/ AUTHORIZATION.
- 199 - NUMBER OF SERVICES EXCEED UTILIZATION AGREEMENT.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. What are the fee guidelines for reimbursement of chronic pain management?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks medical fee dispute resolution in the amount of $26,860.00 for chronic pain management program rendered from November 2, 2021 through December 14, 2021.

   The insurance carrier denied CPT Code 97799-CP with denial reduction codes indicated above.

   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 from MedInsight, dated October 22, 2021. The preauthorization letter indicates the following:

"80 hours of functional restoration program from 10-22-21 through 1-22-22. Review Outcome: Approval. Based on available medical information at the time of the review, MedInsight Utilization Review Guidelines, and in accordance with Texas Rule 134.60, the treatment is medically appropriate.

The disputed services were rendered on November 2, 2021 through December 14, 2021. The insurance carrier did not submit a response to the DWC060 request to support that the requestor exceeded 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 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..."

2. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

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."

28 TAC §134.230 (1)(B) states, "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."

The requestor billed 97799-CP; therefore, the disputed program is not CARF accredited, and reimbursement shall be 80% of the MAR.

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $100/hour	Amount Due
11/2/21	97799-CP	6	$2,370.00	$0.00	$600.00	$600.00
11/3/21	97799-CP	6	$2,370.00	$0.00	$600.00	$600.00
11/10/21	97799-CP	6	$2,370.00	$0.00	$600.00	$600.00
11/15/21	97799-CP	6	$2,370.00	$0.00	$600.00	$600.00
11/29/21	97799-CP	6.5	$2,567.50	$0.00	$650.00	$650.00
11/30/21	97799-CP	6.5	$2,567.50	$0.00	$650.00	$650.00
12/1/21	97799-CP	6.5	$2,567.50	$0.00	$650.00	$650.00
12/6/21	97799-CP	6.5	$2,567.50	$0.00	$650.00	$650.00

12/7/21	97799-CP	6.5	$2,567.50	$0.00	$650.00	$650.00
12/8/21	97799-CP	6.5	$2,567.50	$0.00	$650.00	$650.00
12/14/21	97799-CP	5	$1,975.00	$0.00	$500.00	$500.00
TOTALS		68	$26,860.00	$0.00	$6,800.00	$6,800.00

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 $6,800.00 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 $6,800.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 12, 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.