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

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-22-2449-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 20, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2022 and May 4, 2022	99080-73, and 97799-CP	$1,015.00	$1,015.00
	Total	$1,015.00	$1,015.00

Requestor's Position

"We requested authorization for CPT code 97799 and it was determined to be reasonable and necessary by utilization review (see attached copy) therefore, the above dates of service should be paid in full... The attached dates of service 5/03/2022 had CPT 99080 73 denied in full unnecessarily. DWC-73's are done regularly to check in with patients' progress towards returning to work with no restrictions. I've included below, TDI requirements as well as ODG guidelines regarding DWC-73's and office visits. This dwc-73 should be paid the full $15.00 as the previous dwc-73 was submitted on 4/19/2022 and that is 2 weeks apart from this 5/03/2022 dwc-73."

Amount in Dispute: $1,015.00

Respondent's Position

"The provider acknowledged that the carrier has already reimbursed it $167.22 under CPT code 99213. We are attaching a copy of the carrier's EOBs dated May 31, 2022 and July 11, 2022. With respect to CPT code 99080-73, payment for the covered services are always bundled in the payment for other services. The service requites that a qualifying service be received and covered the qualifying other service has not been received. CPT code 97799 is billed for therapeutic activities and therapeutic exercises. The code requires supporting documentation. The provider is not entitled to any additional reimbursement."

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:

- B15 - THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERIVCE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
- P12 - WORKERS COMPENSATION JURISDICTION FEE SCHEDULE ADJUSTMENT.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.803. THIS BILL HS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is the requestor entitled to reimbursement for CPT Code 99080-73?
2. Is the requestor entitled to reimbursement for CPT Code 97799-CP ?

Findings

1. The requestor seeks reimbursement for CPT Code 99080-73 rendered on May 3, 2022.

   The insurance carrier denied the disputed service with denial reduction codes B15 and W3 (description provided above.)

   CPT code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

   28 TAC §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the

bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 TAC §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the submitted documentations finds that the insurance carriers denial reason is not supported, as a result the requestor is entitled to reimbursement in the amount of $15.00.

2. The requestor seeks reimbursement for CPT Code 97799-CP x 5 units rendered on May 3, 2022 and May 4, 2022. The insurance carrier denied the disputed service with denial reduction code P12 and W3 (description provided above.)

   Review of the submitted documentation supports that the requestor billed and documented a chronic pain management program. As a result, the insurance carrier's denial reason is not supported and the requestor is entitled to reimbursement for the disputed service.

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

28 TAC §134.230(1)(B) states "Accreditation by the CARF is recommended, but not required. (B) 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)…"

28 TAC §134.230(5)(A)(B) 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; 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
5/3/22	97799-CP	5	$500.00	$0.00	$500.00	$500.00
5/4/22	97799-CP	5	$500.00	$0.00	$500.00	$500.00
TOTALS		10	$1,000.00	$0.00	$1,000.00	$1,000.00

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 $1,015.00 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 $1,015.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 17, 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.