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
North Texas Rehabilitation Center

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-22-2491-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
July 26, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4 – 8, 2021	Chronic Pain Management	$3,000.00	$3,000.00

Requestor's Position

The following is a Request for a Medical Fee Dispute Resolution regarding bills denied for authorization. The authorization number was on the HCFA, and the approval letter was attached.

Amount in Dispute: $3,000.00

Respondent's Position

Our initial response to the above referenced medical fee dispute resolution as follows: we have escalated the bills in question for manual review to determine if additional monies are owed.

Response Submitted by: Gallagher Bassett Services, Inc.

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 §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.230 sets out the fee guidelines for chronic pain management services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 90223 – Workers' compensation jurisdictional fee schedule adjustment.
- 93 – No claim level adjustment.

Issues

1. Is North Texas Rehabilitation Center entitled to additional reimbursement?

Findings

1. North Texas Rehabilitation Center is seeking additional reimbursement for chronic pain management services.

   Per 28 TAC §134.230,

   > (5) 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 units 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.

   Documentation submitted supports that North Texas Rehabilitation Center performed and billed seven hours per day of chronic pain management performed on October 4, 5, 6, and 8,

2021. The total allowable reimbursement for the services in question is $3,500.00. Indemnity Insurance Co. of North America reimbursed $500.00. An additional reimbursement of $3,000.00 is recommended.

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.

DWC finds the requester has established that additional reimbursement of $3,000.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Indemnity Insurance Co. of North America must remit to North Texas Rehabilitation Center $3,000.00 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	December 1, 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.