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
Robert Zuniga, D.C.

Respondent Name
Technology Insurance Co., Inc.

MFDR Tracking Number
M4-23-0370-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
October 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
06/22/2022	97799-CP	$800.00	$0.00
06/23/2022	97799-CP	$800.00	$0.00
06/28/2022	97799-CP	$800.00	$0.00
06/29/2022	97799-CP	$800.00	$0.00
06/30/2022	97799-CP	$800.00	$0.00
	Total	$4,000.00	$0.00

Requestor's Position

"*2nd denial dated 9/21/2022 bill: … states recommended allowance $4,000 however no check was previously provided."
Amount in Dispute: $4,000.00

Respondent's Position

The Austin carrier representative for Technology Insurance Co., Inc. is Downs Stanford, PC. The representative was notified of this medical fee dispute on October 27, 2022. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no position statement has been received from the insurance carrier or its representative. However, the carrier has provided explanation of benefits and payment documentation. We will base this decision on the information available at the time of review.
Response Submitted by: N/A

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 Medical Fee Dispute Resolution requests.

2. 28 TAC §134.230 sets out the medical fee guidelines for Return to Work Rehabilitation Programs.

Adjustment Reasons

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

- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Has the requestor been previously paid for any of the dates of service in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $4,000.00 for disputed services rendered from June 22, 2022, through June 30, 2022.

Review of submitted documentation finds that the requestor billed the insurance carrier $5,000.00 for services rendered on the above disputed dates of service.

A review of the explanation of benefits submitted, dated September 21, 2022, finds that the insurance carrier allowed reimbursement to the requestor in the amount of $4,000.00 for services in dispute. Review of additional documentation submitted finds that the insurance carrier issued a check to the requestor dated March 21, 2023, in the amount of $4,000.00 for the disputed dates of service.

The DWC finds that the requestor has previously been reimbursed for the disputed dates of service in the amount of $4,000.00.

2. The DWC finds that 28 TAC §134.230, which sets out the fee guideline for chronic pain management services, applies to the reimbursement of CPT code 97799-CP. 28 TAC §134.230(1) 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). (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) 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 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."

Review of submitted documentation finds:
• The requestor billed for a non-CARF accredited chronic pain management program using code 97799-CP.
• The requestor is seeking medical fee dispute resolution in the amount of $4,000.00 for 40 hours of CPT code 97799-CP rendered from June 22, 2022, through June 30, 2022.
• Per 28 Texas Administrative Code §134.230(1) and (5), the following formula is used to calculate the MAR: 80% of $125.00 = $100.00 X 40 hours = $4,000.00.

The respondent paid $4,000.00. The DWC finds that the requestor is not entitled to additional reimbursement for the disputed dates of service.

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 Division finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the Division has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature:

		August 15, 2023
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.tas.gov.