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
OCCUFIT

Respondent Name
TECHNOLOGY INSURANCE COMPANY

MFDR Tracking Number
M4-23-0447-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
October 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 28, 2022 through August 5, 2022	97799-CP	$3,200.00	$3,200.00
	Total	$3,200.00	$3,200.00

Requestor's Position

"Our office received an explanation of review for date of services: 07 /26/2022-08/05/2022, based on explanation codes; P12 (workers compensation jurisdictional fee schedule adjustment) 320 (non-accredited) 95 (plan procedures not followed) U05 (exceeds the ur amount authorized). I have reviewed the EOB and it shows 480 units our office did not submitted for 480 units, the submitted health insurance claim form 1500 was submitted with 8 units not 480 units."

Amount in Dispute: $3,200.00

Respondent's Position

"I just sent the email on 11/15/2022 stating I had requested it be corrected. Unfortunately, corrections take longer than 7 days." [In response to a $0.00 pay EOB.]

Response Submitted by: Downs Stanford, P.C.

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, 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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 320 – Non-Accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
- 95 – Plan procedure not followed.
- U05 – The billed service exceeds the ur amount authorized.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies.
- U03 – the billed service was reviewed by UR and authorized.
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks medical fee dispute resolution in the amount of $3,200.00 for chronic pain management services rendered from July 28, 2022 through August 5, 2022.

   The insurance carrier denied CPT Code 97799-CP with denial reduction codes "U05," and "95."

   28 Texas Administrative Code §134.600 (p) states, "non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation…"

Review of the preauthorization letter dated July 11, 2022, review #5624281, supports that the requestor obtained preauthorization for chronic pain management, (80 hours), approval start and end dates: July 11, 2022 through January 11, 2023. The dates of service in dispute are July 18, 2022 through August 5, 2022. The requestor documented in their medical records that eight (8) hours of chronic pain management services were rendered for each disputed date of service for a total of 32 hours rendered.

Based on the documentation contained in the dispute, the DWC finds that the requestor documented 32 hours of chronic pain service, and rendered the services within the preauthorized time frame. As a result, the insurance carrier's denial reasons are not supported. The DWC finds that the requestor is therefore entitled to reimbursement for the disputed services.

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 (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% 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."

   Review of the medical bills documents the billing of eight units for CPT code 97799-CP for each disputed date of service. The requestor did not append modifier – CA modifier, as a result, the DWC finds that the chronic pain management services are non-CARF accredited and therefore the requestor is entitled to reimbursement at 80% of the MAR, per 28 TAC 28 TAC §134.230(1)(B).

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $125 x 80% = MAR $100.00	Amount Due
7/28/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
8/1/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
8/3/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
8/5/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
TOTALS		32	$3,200.00	$0.00	$3,200.00	$3,200.00

The DWC finds that the requestor has established that reimbursement in the amount of $3,200.00 is due. Therefore, this amount 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.

The DWC finds the requester has established that reimbursement of $3,200.00 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 $3,200.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 17, 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 managing 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.