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

General Information

Requestor Name
NORTH TEXAS REHABILITATION

Respondent Name
CHEROKEE INSURANCE COMPANY

MFDR Tracking Number
M4-23-0450-01

Carrier's Austin Representative
Box Number 16

DWC Date Received
October 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 8, 2021 through February 1, 2022	97799-CP-CA	$6,000.00	$6,000.00
	Total	$6,000.00	$6,000.00

Requestor's Position

"The following is a Request for Reconsideration for date of service, December 08, 2021. This bill was submitted for $2800.00, 97799CP, CA for 8 hours and was only processed for $0.00. this bill was denied for 'Unlisted procedure, resubmit with a more descriptive code.' According to the Texas Department of Insurance, Texas Workers Compensation, 134.204 Medical Fee Guideline for Workers' Compensation Specific Services, a Chronic Pain Program is to be paid at $125 per hour for a 'CARF Accredited Facility."

Amount in Dispute: $6,000.00

Respondent's Position

The Austin carrier representative for Cherokee Insurance Company is Adami Shuffield Scheihing Burn. Adami Shuffield Scheihing Burn was notified of this medical fee dispute on October 25, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14-calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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:

- 189 – Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
- * – This is an unlisted procedure. Please resubmit with a more descriptive code.

Issues

1. Did the insurance carrier respond to the DWC060 request?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent failed to submit a position summary for consideration in this dispute. As a result, the information available at the time of review is what led to this conclusion.
2. The requestor is seeking medical fee dispute resolution in the amount of $6,000.00 for chronic pain management services rendered December 8, 2021 through February 1, 2022.

   The insurance carrier denied CPT Code 97799-CP-CA with denial reduction code "189". (description provided above.)

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

   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 documentation submitted for consideration in this dispute, finds that the requestor documented and billed CPT code 97799-CP-CA, in accordance with 28 TAC §134.230. The DWC finds that the insurance carrier's denial reason is not supported. The requestor is due reimbursement for the disputed dates of service.

3. 28 TAC §134.230(1)(A) 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)…"

   Review of the submitted documentation finds that the requestor billed CPT Code 97799-CP and appended modifier –CA to identify that the chronic pain management services are CARF accredited, as a result, reimbursement is calculated per 28 TAC §134.230(1)(A) and 28 TAC §134.230(5)(A)-(B).

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $125/hour	Amount Due
12/8/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
12/14/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
12/15/21	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
1/24/22	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
1/31/22	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
2/1/22	97799-CP-CA	8	$1000.00	$0.00	$1000.00	$1000.00
TOTALS			$6,000.00	$0.00	$6,000.00	$6,000.00

The DWC finds that the requestor has established that reimbursement in the amount of $6,000.00 is recommended for the chronic pain management services rendered on December 8, 2021 through February 1, 2022.

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 $6,000.00 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 $6,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 8, 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 three 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.