Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PRIORITY HEALTH & WELLNESS

Respondent Name
AIU INSURANCE COMPANY

MFDR Tracking Number
M4-23-0568-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 27, 2022 through June 15, 2022	97799-CP	$8,000.00	$8,000.00
	Total	$8,000.00	$8,000.00

Requestor's Position

"…this is not an extent of injury issue as the dates of service in this dispute were for the first 80 hours of a chronic pain management program and the carrier remitted payment for the second set of 80 hours of the chronic pain management program using the same ICD-10 code. Additionally, the carrier remitted payment for 160 hours of work hardening program using the same ICD-10 code. All claims were submitted initially submitted using the ICD-10 code…which was an accepted condition. When the aforementioned EOB was received for the disputed dates based on extent of injury, the claim was resubmitted with the ICD-10… which is also an accepted condition. However, payment was once again denied as a duplicate service. Therefore, in this particular case, the reasons for the initial denial as well as the denial in response to the reconsideration are all invalid reasons for denial as the claim as they were billed under conditions accepted by the carrier and as the carrier had paid for previous claims, they are obviously the correct payer for this claim. Therefore, Priority Health & Wellness requests Gallagher Bassett remit the balance due of $8,000.00 for said procedures performed on said patient on said dates."

Amount in Dispute: $8,000.00

Respondent's Position

"It appears that the provider changed the ICD-10 diagnosis code between the filing of the first CMS-1500 and the second one. The provider did not include a copy of the first one in its DWC-60 packet, it included the second one which was dated July 11, 2022. With the change of the diagnosis code at box 21, the CMS-1500 was dated July 11, 2022 would actually be the initial medical bill for the diagnosis code then being pursued. The provider never filed a request for reconsideration following the carrier's response to that CMS-1500. We have reached out to the DPA to obtain additional information on their end. However, we would ask that the provider send the undersigned a full copy of all of the CMS-1500s and the EOBs for the dates of service in question. The carrier will be supplementing its response."

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 §133.305, sets out the general guidelines for medical dispute resolution.
3. 28 TAC §134.230, sets out the reimbursement guidelines for return-to-work rehabilitation programs.
4. 28 TAC §133.250, sets out the reconsideration for payment of medical bills.
5. 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:

- 90147 & 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- ZK10 – Resolution manager denial.
- 219 – Based on extent of injury.
- 90086 & 18 – Exact duplicate claim/service.
- 306 – Billing is a duplicate of other services/performed on same day.

Issues

1. Did the requestor request reconsideration prior to the filing of the MDR?
2. Is the Insurance Carrier's denial of extent of injury supported?
3. What are the fee guidelines for non-CARF accredited chronic pain management services?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for a non-CARF accredited chronic pain management services rendered on May 27, 2022 through June 15, 2022.

   The insurance carrier states, "With the change of the diagnosis code at box 21, the CMS-1500 was dated July 11, 2022 would actually be the initial medical bill for the diagnosis code then being pursued."

   28 TAC §133.250 (d)(1) states, "(d) A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."

   Review of the medical documentation supports that the requestor sought reconsideration in accordance with 28 TAC §133.250 (d)(1). The DWC finds that the insurance carrier's denial reason is not supported, as a result the disputed services are eligible for review.

2. The requestor billed the insurance carrier CPT Code 97799-CP on May 27, 2022 through June 15, 2022.

   The insurance carrier denied the disputed services with denial reduction codes 90147 & 109 and 219.

   28 TAC §133.305(b) states, "(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   Review of the documentation submitted by the parties, finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

   The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is ripe for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

3. The fee guideline for chronic pain management services is found at 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."

Review of the submitted documentation finds that the requestor billed CPT Code 97799-CP and did not appended modifier –CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement shall be 80% of the MAR, per 28 TAC §134.230(1)(B).

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR 80% $100/hour	Amount Due
5/27/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
5/31/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/1/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/2/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/7/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/8/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/10/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/13/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/14/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
6/15/22	97799-CP	8	$800.00	$0.00	$800.00	$800.00
TOTALS		10	$8,000.00	$0.00	$8,000.00	$8,000.00

4. The DWC finds that the requestor has established that reimbursement is due for the disputed services. As a result, the requestor is entitled to reimbursement in the amount of $8,000.00.

<u>Conclusion</u>

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Although all the evidence may not have been discussed in this audit, it was considered in the review.

The DWC finds the requester has established that reimbursement of $8,000.00 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 $8,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

____________________	____________________	April 18, 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.texas.gov.