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
DALLAS DOCTOR'S PROFESSIONAL

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-23-0627-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 10, 2021 through December 21, 2021	97799-CP	$7,250.00	$1,700.00
	Total	$7,250.00	$1,700.00

Requestor's Position

"These claims have been submitted and denied previously, as the incorrect authorization number was provided. The CORRECT AUTHORIZATION # IS 4962337. The authorization letter from Medinsights for these medically necessary services is enclosed. Herein we have provided not only a copy of the prior authorization letter, but new claim forms for services rendered, as well as medical records to support such services. We expect that these claims shall be expedited timely with payment forthcoming to our office..."

Amount in Dispute: $7,250.00

Respondent's Position

The Austin carrier representative for Zurich American Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on November 15, 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 in accordance 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:

- 5406 - CV: RECONSIDERATION, ADDITIONA ALLOWANCE RECOMMENDED. THIS BILL AND SUBMITTED DOCUMENTATION HAVE BEE RE-EVALUATED BY CLINICAL VALIDATION.
- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS, SUBMIT A COPY OF THIS EOR.
- P12 & 90223 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 90950 - THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL; ALLOWANCE AMOUNTS REFLECT ANY CHANGES TO THE PREVIOUS PAYMENT.
- 309 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 4845 - BILL REVIEW RULES REDUCTION APPLIED.

Issues

1. Did the insurance carrier issue a payment to resolve the MDR dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks medical fee dispute resolution in the amount of $7,250.00, for a chronic pain management program rendered from November 10, 2021 through December 21, 2021.

   Review of the additional EOBs submitted after the MDR request revealed that the insurance carrier issued payments totaling $4,100.00 for dates of service November 10, 2021 and November 11, 2021, November 15, 2021 through November 17, 2021, and December 3, 2021 through December 21, 2021. The provider therefore requests additional payment for dates of service November 12, 2021, November 18, 2021 through December 2, 2021.

   The insurance carrier issued payments for CPT Code 97799-CP and reduced the remaining charges with the denial reason codes indicated above. Review of the submitted documentation finds that the insurance carrier's denial reasons are not supported. As a result, the requestor is entitled to additional reimbursement for the remaining chronic pain management services.

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

   28 TAC §134.230 (1) (B) states, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier. (1) 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) 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 is calculated per 28 TAC §134.230(1)(B) and 28 TAC §134.230(5)(A)-(B).

   The disputed program is not CARF accredited, and reimbursement shall be 80% of the MAR.

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR (80%) $100/hour	Amount Due
11/10/21	97799-CP	6	$750.00	$600.00	$600.00	$0.00
11/11/21	97799-CP	1	$125.00	$100.00	$100.00	$0.00
11/12/21	97799-CP	2	$250.00	$0.00	$200.00	$200.00
11/15/21	97799-CP	6	$750.00	$600.00	$600.00	$0.00
11/16/21	97799-CP	1	$125.00	$100.00	$100.00	$0.00
11/17/21	97799-CP	6	$750.00	$600.00	$600.00	$0.00
11/18/21	97799-CP	1	$125.00	$0.00	$100.00	$100.00
11/19/21	97799-CP	2	$250.00	$0.00	$200.00	$200.00
11/29/21	97799-CP	6	$750.00	$0.00	$600.00	$600.00
11/30/21	97799-CP	1	$125.00	$0.00	$100.00	$100.00
12/1/21	97799-CP	6	$750.00	$0.00	$600.00	$600.00

12/2/21	97799-CP	1	$125.00	$0.00	$100.00	$100.00
12/3/21	97799-CP	3	$375.00	$300.00	$300.00	$0.00
12/6/21	97799-CP	6	$750.00	$600.00	$600.00	$0.00
12/7/21	97799-CP	1	$125.00	$100.00	$100.00	$0.00
12/8/21	97799-CP	6	$750.00	$600.00	$600.00	$0.00
12/20/21	97799-CP	2	$250.00	$200.00	$200.00	$0.00
12/21/21	97799-CP	1	$125.00	$300.00	$100.00	$-200.00
TOTALS		58	$7,250.00	$4,100.00	$5,800.00	$1,700.00

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. Although not all of the evidence was discussed, it was considered.

The DWC finds the requester has established that additional reimbursement of $1,700.00 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 the Respondent must remit to the Requestor $1,700.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 27, 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.