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
NORTH TEXAS REHABILITATION

Respondent Name
HARTFORD CASUALTY INSURANCE CO.

MFDR Tracking Number
M4-23-1036-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
January 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 23, 2022 through June 1, 2022	97799-CP-CA	$6,562.00	$2,350.00
	Total	$6,562.00	$2,350.00

Requestor's Position

"All dates of service have been paid except 05/23/2022, 05/31/2022 and 06/01/2022. I am resubmitting this claim because we have not received any form of payment, even though you have paid the rest of the dates of services in the same case. Based on the following information we would appreciate it if you would process this claim accordingly."

Amount in Dispute: $6,562.00

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: The bills in question have been denied based on extent of injury. Attached please find the bills and corresponding EOB along with a copy of the PLN 11."

Response Submitted by: Gallagher Bassett

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.

Denial Reasons

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

- 90202 & B13– Previously paid payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Did the insurance carrier raise a new issue after the filing of the MDR?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks medical fee dispute resolution for chronic pain management services, rendered on 05/23/2022, 05/31/2022 and 06/01/2022. The insurance carrier states, "The bills in question have been denied based on extent of injury. Attached please find the bills and corresponding EOB along with a copy of the PLN 11."

   The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review. The submitted documentation does not support that a denial based on extent of injury was provided to the requestor before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

   The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied CPT Code 97799-CP-CA with denial reduction codes indicated above. Review of the documentation submitted for review, supports that the requestor billed and rendered chronic pain management services. The DWC finds that the insurance carrier's denial reasons are not supported. The requestor is therefore entitled to reimbursement.

3. The fee guidelines for the chronic pain management services are found in 28 TAC §134.230.

   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)…"

   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 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)(A) and 28 TAC §134.230(5)(A)-(B).

   The requestor billed 97799-CP-CA-GP; therefore, the disputed services are CARF accredited, and reimbursement shall be 100% of the MAR

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $125/hour	Amount Due
5/23/22	97799-CP-CA	8	$2,800.00	$0.00	$1,000.00	$1,000.00
5/31/22	97799-CP-CA	6.8	$2,362.00	$0.00	$850.00	$850.00
6/1/22	97799-CP-CA	4	$1,400.00	$0.00	$500.00	$500.00
TOTALS		18.8	$6,562.00	$0.00	$2,350.00	$2,350.00

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. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $2,350.00 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 $2,350.00 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.