



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MARCUS PAUL HAYES, DC

Respondent Name

TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number

M4-23-1043-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

January 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 23, 2022 through July 8, 2022	97799-CP	\$5,000.00	\$5,000.00
Total		\$5,000.00	\$5,000.00

Requestor's Position

"This is a reconsideration claim that has been partial paid, per reason of denial 'total time spent is not documented in medical records.' I have attached an addendum of medical records to the reconsideration claim. Please review the submitted reconsideration claim and upon review please issue payment."

Amount in Dispute: \$5,000.00

Respondent's Position

"The Carrier reimbursed 3 units per day based on the documentation submitted with the billing. The documentation reflects that the Claimant attends the program from noon till 3:00 each day as reflected in the progress notes. Subsequent to submitting the original billing (attached), the provider amended the documentation with handwritten notations that the Claimant attended the program from 8:30 to 4:30 each day. There is no documentation submitted, such as sign in sheets or program notes, justifying that additional time. Consequently, the Carrier contends the documentation supports only the 3 hours previously reimbursed."

Response Submitted by: Travelers

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:

- W3 – Bill is a reconsideration or appeal.
- 947 – Upheld no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

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 \$5,000.00 for a non-CARF accredited chronic pain management program rendered on June 23, 2022 through July 8, 2022.

The insurance carrier denied CPT Code 97799-CP with denial reduction code above.

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 submitted documentation supports that the requestor obtained preauthorization for CPT Code 97799-CP. The preauthorization letter from Travelers, dated June 21, 2022 indicates the following:

"On behalf of Travelers Indemnity Company, we have determined that the request for Chronic Pain Management X10 sessions CPT-97799... is determined to be medically necessary and is approved. The Injured worker will receive the approved treatment at facility of choice. The UR Number for this request is 7FLG1943."

The requestor seeks reimbursement for dates of service June 23, 2022 through July 8, 2022.

The preauthorization letter approved dates of service, 6/21/22 through 7/21/22. The DWC finds that the services in dispute were rendered within the preauthorized timeframes.

28 Texas Administrative Code §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, "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 medical documentation supports the billing of 8 hours of chronic pain management for each disputed date of service. The DWC therefore finds that the insurance carrier's denial reasons are not supported. The requestor is therefore entitled to reimbursement for the services in dispute.

Review of the submitted documentation finds that the requestor billed CPT Code 97799-CP and did not append 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
6/23/22	97799-CP	8	\$500.00	\$300.00	\$800.00	\$500.00
6/24/22	97799-CP	8	\$500.00	\$300.00	\$800.00	\$500.00

