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
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-23-1130-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
January 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 15, 2022	97799-CP x 6 units	$900.00	$600.00
	Total	$900.00	$600.00

Requestor's Position

"Please see the attached Explanation of Benefits, DCN #2022059DD21517. This was the first EOB we received, along with check #0177777310 in the amount of $900.00. The EOB shows payment was allowed for date of service 2/15/22. Payment for date of service 2/9/22 was denied. The check for $900 was deposited, but soon after we received a letter from our bank showing the Carrier stopped payment on the check. See attached documentation… The second issue was related to DOS 2/15/22. As mentioned above, payment was initially recommended. I contacted the bill review department on 8/31/22 and was informed this DOS was paid on 8/21/22 with check #0181541154. This check was received, but only in the amount of $900. This was applied to DOS 2/9/22."

Amount in Dispute: $900.00

Respondent's Position

"Please find the attached DWC-60 letter with EOBs, payment bills for the claimant listed above."

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, 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:

- 90213 & P2 – Not a work-related injury/illness and thus not the liability of the workers compensation carrier.
- 5967 – Billed charges are being denied in accordance with TX 133.240 (C)(h)(3).
- 5969 – CV processor ready to resolve rules.
- 90950 – This bill is a reconsideration of a previously reviewed bill; allowance amounts reflect any changes to the previous payment.

Issues

1. Does the dispute contain unresolved compensability, extent of injury and/or liability (CEL) issues?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement in the amount of $900.00 for date of service February 15, 2022. The insurance carrier denied the disputed service with denial reason codes, 90213, 5967 and P2 (description provided above.)

   28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   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 eligible 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.

2. The insurance carrier denied CPT Code 97799-CP-CA with denial reduction code 5969 (description provided above.)

   The requestor states, "The check for $900 was deposited, but soon after we received a letter from our bank showing the Carrier stopped payment on the check."

   Review of the submitted documentation supports that the requestor issued a payment in the amount of $900.00 for the disputed service, and then stopped payment for this service. The DWC concludes the insurance carrier did not provide sufficient documentation to support the reasons for recoupment of payment. The DWC therefore finds that the requestor is entitled to reimbursement for the six hours of chronic pain management rendered on February 15, 2022.

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

   The requestor billed 97799-CP; therefore, the disputed program is not CARF accredited, and reimbursement shall be 80% of the MAR.

   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).

   Date of service February 15, 2022, the requestor billed 6 units, reimbursement is 80% of $125.00, as a result reimbursement is $100.00 x 6 units, for a MAR amount of $600.00. The insurance paid $0.00; the requestor is therefore entitled to reimbursement in the amount of $600.00.

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 $600.00 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 $600.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 17, 2023 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 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.