TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-23-1180-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
January 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 7, 2022 and March 8, 2022	97799-CP-CA	$1,925.00	$1,375.00
	Total	$1,925.00	$1,375.00

Requestor's Position

"Carrier has taken final action pursuant to §133.2 (g), and issued a denial of reimbursement, stating that request for reconsideration were duplicate bills. That denial is incorrect. Reconsideration requests were sent subsequent to the denial of the original bills pursuant to §133.2 (g)(B) and §133.250. The bills were not duplicates and no other denial reasons were given."

Amount in Dispute: $1,925.00

Respondent's Position

"This dispute concerns services provided by North Texas Pain Recovery Center on March 7 and March 8, 2022. After additional review, Hartford is reprocessing the medical bill and will issue an additional payment to North Texas Pain Recovery Center."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 Return-to-Work Rehabilitation Programs.
3. 28 TAC §134.203 sets out the Medical Fee Guideline for Professional Services.
4. 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:

- P010 – Internal use only.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

Issues

1. Is the insurance carrier's denial reason supported?
2. Did the requestor obtain preauthorization for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks medical fee dispute resolution in the amount of $1,925.00 for chronic pain management services rendered from March 7, 2022 and March 8, 2022.

   In its position statement, Burns Anderson Jury & Brenner, L.L.P., states in pertinent part, "…Hartford is reprocessing the medical bill and will issue an additional payment to North Texas Pain Recovery Center." As of today's review, the DWC finds that no documentation was submitted by the insurance carrier to support that a payment was issued for the disputed services, as a result, the disputed services are reviewed pursuant to the applicable rules and guidelines.

2. Review of the submitted documentation supports that the requestor obtained preauthorization from Sedgwick for chronic pain management services, with a start date of January 17, 2022 and an end date of April 17, 2022. The disputed dates of services were rendered within the preauthorized timeframe. As a result, the requestor is entitled to reimbursement.

28 Texas Administrative Code §134.600 (p) states, "non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation…"

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..."

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

   The requestor billed 97799-CP-CA; therefore, the disputed program is CARF accredited, and reimbursement shall be 100% of the MAR.

   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).

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $125/hour	Amount Due
03/07/22	97799-CP-CA	8	$1,400.00	$0.00	$1,000.00	$1,000.00
03/08/22	97799-CP-CA	3	$525.00	$0.00	$375.00	$375.00
TOTALS			$1,925.00	$0.00	$1,375.00	$1,375.00

The DWC finds that the requestor is entitled to reimbursement in the amount of $1,375.00. Therefore, this amount is recommended.

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 $1,375.00 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 $1,375.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 2, 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.