



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Patient Care Injury Clinic
PA

Respondent Name

Arch Indemnity Insurance Co.

MFDR Tracking Number

M4-23-1224-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
11/18/2022	97799-CP CA GP	\$500.00	\$250.00
Total		\$500.00	\$250.00

Requestor's Position

"... We obtained preauthorization according to division rules and regulations. I attached the letter certified on June 30, 2022 with date range until December 31, 2022... We feel that our facility should be paid according to the fee schedule guidelines of a CARF accredited "

Amount in Dispute: \$500.00

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment. Supplemental response will be provided once the bill auditing company has finalized their review... "

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 payment for the disputed date of service rendered on November 8, 2022, with the following claim adjustment codes:

- 197 – Payment denied / reduced for absence of precertification / authorization.
- 193 – original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 199 – Number of services exceeds utilization agreement.

Issues

1. Is the insurance carrier's (IC) denial reason justified?
2. Is the Requester entitled to additional reimbursement for disputed date of service November 18, 2022?

Findings

1. The IC denied reimbursement to the requester for the disputed service 97799-CP, CA, GP rendered on November 18, 2022, based on lack of preauthorization.

Review of submitted documentation finds that the service date and CPT code in dispute was preauthorized.

The division notes that as of the date of this MFDR adjudication, the IC has not provided a supplemental position statement as the IC indicated it would in its initial position statement.

The division finds that the denial reason is not justified.

2. The requester, a CARF accredited provider, is seeking reimbursement for CPT code 97799-CP, CA, GP. The division finds that 28 TAC §134.230 applies to the reimbursement of this disputed

service.

28 TAC §134.230(1) in pertinent part states, "(1) 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). (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.... (5)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 units 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 submitted medical record for date of service November 18, 2022, finds that on the first page, at the top of the form titled "CHRONIC PAIN MANAGEMENT PROGRAM", documents 2 hours of total time of service 97799-CP, CA, GP on November 18, 2022.

In accordance with TAC §134.230, the following calculation is applied to determine MAR for 2 units of CPT 97799-CP, CA, GP:

$\$125 / \text{unit} \times 2 \text{ units} = \250.00 MAR

Submitted documentation finds that the IC reimbursed the requester \$0.00.

The division finds that the requester is entitled to \$250.00 reimbursement for CPT code 97799-CP, CA, GP rendered on November 18, 2022.

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 division finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the division has determined the requester is entitled to reimbursement for the disputed services.

It is ordered that Arch Indemnity Insurance Co. must remit to Patient Care Injury Clinic PA \$250.00

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 23, 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 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 electrónico CompConnection@tdi.texas.gov.