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
PATIENT CARE INJURY CLINIC

Respondent Name
SOMPO AMERICA INSURANCE COMPANY

MFDR Tracking Number
M4-23-1524-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2022 through November 18, 2022	97799-CP-CA-GP	$2,500.00	$2,500.00
	Total	$2,500.00	$2,500.00

Requestor's Position

"Our facility has been having difficulties with the above carrier in processing our bills according to absence of precertification/authorization...We obtained preauthorization according to division rules and regulations. I attached the letter certified on October 13, 2022 with date range until February 11, 2023. I also attached a chart table to assist with any confusion on the number of occurrences. We feel that our facility should be paid according to the fee schedule guidelines of a CARF accredited."

Amount in Dispute: $2,500.00

Respondent's Position

"...the carrier has already paid the provider for the very services that the provider is claiming reimbursement. We are attaching a copy of the carrier's EOBs. The first EOB is dated February 7, 2023 and covers the three dates of service in question. The EOB recommended payment of $2,500. The provider has been paid that amount. Accordingly, the provider should withdraw his request for Medical Fee Dispute Resolution. We are attaching a copy of the remaining EOBs that cover the other 75 hours of chronic pain management which the carrier has paid."

Response Submitted by: Flahive, Ogden & Latson

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.
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:

- 5920 – Fee schedule manually priced at billed charges.
- 5406 – CV: Reconsideration, additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation.
- 90950 – This bill is a reconsideration of a previously reviewed bill; allowance amounts reflect any changes to the previous payment.
- 5403 – CV: This bill qualified for the clinical validation program, no reductions applied.
- 5721 – To avoid duplicate bill denial for all reconsiderations; adjustments additional payment requests, submit a copy of this EOR or clear notation that a recon…

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Does 28 TAC §134.230 set out the reimbursement guidelines for chronic pain management services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for chronic pain management services rendered on November 15, 2022 through November 18, 2022. The insurance carrier issued payments to the requestor for CPT Code 97799-CP-CA.

   The insurance carrier's position states in pertinent part, "…the carrier has already paid the provider for the very services that the provider is claiming reimbursement."

   28 TAC §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..."

The insurance carrier indicates that a payment has been issued for the services in dispute. As a result, the DWC will determine if the insurance carrier issued payments in accordance with the applicable rules and guidelines.

2. The fee guideline for chronic pain management services is found at 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-GP; 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	Date Paid / Check #	MAR $125/hour	Amount Due
11/15/22	97799-CP-CA	7	$875.00	$0.00	004310	$875.00	$875.00
11/17/22	97799-CP-CA	7	$875.00	$0.00	004310	$875.00	$ 875.00
11/18/22	97799-CP-CA	6	$750.00	$0.00	004310	$750.00	$750.00
TOTALS		20	$2,500.00	$0.00		$2,500.00	$2,500.00

3. The insurance carrier's position states in relevant part, "The first EOB is dated February 7, 2023 and covers the three dates of service in question." Review of the EOB does not indicate that a payment in the amount of $2,500.00 was issued, as indicated by the respondents. The EOB contains a copy of the check with check #004310, however the amount recommended is $0.00. The DWC finds that the requestor is therefore entitled to $2,500.00 for the disputed services. As a result, $2,500 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 $2,500.00 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 $2,500.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 19, 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.