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**
Peak Integrated Healthcare

**Respondent Name**
New Hampshire Insurance Co.

**MFDR Tracking Number**
M4-23-2123-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
April 28, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| 11/08/2022 | 97799-CP | $200.00 | $0.00 |
| | **Total** | $200.00 | $0.00 |

## Requestor's Position

Requestor's position summary taken from the request for reconsideration:
"This 11/8/2022 date of service we discovered is NOT paid in full. Please process payment in full."
**Amount in Dispute:** $200.00

## Respondent's Position

"... The Carrier has reviewed the documentation and determined the Provider is not entitled to additional reimbursement for the dispute services. The Provider billed for 5 units (5 hours) of CPT 97799-CP. The documentation... documents the Claimant's Time In as 9:00 am and Time Out as 12:00 pm, for a total of 3 hours. The Carrier properly reimbursed the Provider for the 3 units of CPT 97799-CP documented. The Provider is not entitled to the full 5 units billed based on the documentation... "
**Response Submitted by:** New Hampshire Insurance Co. of Midwest

# 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:

- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 1001 – Based on the corrected billing and/or additional information / documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2008 – Additional payment made on appeal / reconsideration.

Issues

1. Is the Requester entitled to additional reimbursement for disputed date of service November 18, 2022?

Findings

1. The requester, a non-CARF accredited provider, is seeking additional reimbursement for CPT code 97799-CP. 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 8, 2022, finds that on the first page, in the top row of the form titled "WORK HARDENING/WORK CONDITIONING/CHRONIC PAIN MANAGEMENT", documents the injured worker's "time in" for chronic pain treatment as 9:00am and "time out" as 12:00pm. The division finds that the other column and row headings of the medical record are not legible. Therefore, the division finds the total time documented on disputed date of service to be 3 hours/3units .

In accordance with TAC §134.230, the following calculation is applied to determine MAR for 3 units of CPT 97799-CP:

$125 / unit x 3 units = $375.00 MAR; 80% (non-CARF provider) of MAR = $300.00

Submitted documentation finds that the IC reimbursed the requester $300.00, after reconsideration request and bill review, for CPT 97799-CP, rendered on November 8, 2022.

The division finds that the IC properly reimbursed the requester for the disputed service in accordance with 28 TAC §134.230, which sets out the reimbursement guidelines for return to work rehabilitation programs. Therefore, the division finds that the requester is not entitled to additional reimbursement for CPT code 97799-CP rendered on November 8, 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 not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | May 22, 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.