



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PRIDE

Respondent Name

ABF FREIGHT SYSTEM INC.

MFDR Tracking Number

M4-23-2184-01

Carrier's Austin Representative

Box Number 01

DWC Date Received

May 4, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 31, 2022 through November 30, 2022	97799-CP-CA-GP-GO	\$6,375.00	\$6,375.00
Total		\$6,375.00	\$6,375.00

Requestor's Position

"The above date of service was denied in error. The claim was reduced to \$0 per hour with the rational code of fair and reasonable. The current procedural terminology code 97799-CP-CA is an unlisted physical medicine/rehabilitation service and/or procedure. The modifier CP is for chronic pain management and the CA modifier is for CARF accredited programs. The commission agrees with the commenter's support of the reimbursement rate for interdisciplinary pain management programs in the amount of \$125 .00 per hour is the maximum allowed reimbursement for this procedure code."

Amount in Dispute: \$6,375.00

Respondent's Position

"The bills were all timely reviewed and reduced by Carrier's bill review company. Requestor complains of seven (7) charges that it submits were improperly reduced or not paid. Bill review reduced the amounts which carrier paid. The explanation of the charges exceeds the maximum units of service considered reasonable and necessary."

Response Submitted by: The Silvera Firm

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.
4. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
5. 28 TAC §102.4 sets out the rules for non-Commission communications.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- MUE01 – Denied – exceeds maximum units of service considered reasonable and necessary.
- 29 –Time limit for filing has expired. "Fri, Mar 31, 2023 17:37 PM [burns]**deny-timely filing.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the requestor forfeit the right to reimbursement for the services in dispute?
2. Is the Insurance Carrier's denial reason supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$6,375.00 for chronic pain management services rendered from October 31, 2022 through November 30, 2022. The insurance carrier denied the disputed dates due to 95-day timey filing.

28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

28 TAC §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

Upon review of the presented documentation, it is determined that there is adequate evidence to substantiate the allegation that a medical bill was submitted within 95 days of the date the services were rendered. Therefore, payment consideration is allowed for the disputed services provided by the requestor.

2. The insurance carrier denied CPT Code 97799-CP-CA rendered on October 31, 2022 through November 30, 2022 with denial reduction code MUE01 – Denied – exceeds maximum units of service considered reasonable and necessary.

28 TAC §134.600 (p) states, “non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation...”

Review of the submitted documentation finds that the requestor obtain prior authorization from Novare on October 18, 2022 for CPT 97799 with a start date of October 13, 2022 and an end date of January 31, 2023. The requestor seeks reimbursement for dates of service October 31, 2022 through November 30, 2022. The DWC finds that the services in dispute were rendered within the preauthorized timeframes. As a result, the DWC finds that the insurance carrier’s denial reason is not supported, and the requestor is entitled to reimbursement for the services in dispute.

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...”

3. The fee guidelines 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.”

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).

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

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR \$125/hour	Amount Due
10/31/22	97799-CP-CA	8	\$875.00	\$125.00	\$1,000.00	\$875.00
11/2/22	97799-CP-CA	8	\$875.00	\$125.00	\$1,000.00	\$875.00
11/4/22	97799-CP-CA	8	\$875.00	\$125.00	\$1,000.00	\$875.00

11/21/22	97799-CP-CA	8	\$1,000.00	\$0.00	\$1,000.00	\$1,000.00
11/22/22	97799-CP-CA	8	\$1,000.00	\$0.00	\$1,000.00	\$1,000.00
11/28/22	97799-CP-CA	8	\$875.00	\$125.00	\$1,000.00	\$875.00
11/30/22	97799-CP-CA	8	\$875.00	\$125.00	\$1,000.00	\$875.00
TOTALS		56	\$6,375.00	\$625.00	\$7,000.00	\$6,375.00

The DWC finds that the requestor is entitled to reimbursement in the amount of \$6,375.00. 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 \$6,375.00 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 \$6,375.00 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	August 1, 2023 Date
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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).