



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

HORIZON EVALUATORS, INC.

**Respondent Name**

FRANK WINSTON CRUM INSURANCE INC

**MFDR Tracking Number**

M4-17-0136-01

**Carrier's Austin Representative**

Box Number 06

**MFDR Date Received**

SEPTEMBER 19, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "I have included all medical documentation for this date of service, EOB, both denial letters, Pre-Authorization letter, DWCO60 Form and HICFA."

**Amount in Dispute:** \$3,875.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2015 October 8, 2015 October 14, 2015 October 19, 2015 October 26, 2015	CPT Code 97799-CP X 8 hours per day X 5 dates = 40 hours Chronic Pain Management Program	\$775.00/ day X 5 dates = \$3,875.00	\$3,875.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 320-Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
  - 224-Duplicate charge.
  - 18-Exact duplicate claim/service.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 26, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

## Issues

Is the requestor entitled to additional reimbursement for chronic pain management program?

## Findings

The requestor billed CPT code 97799-CP for a non-CARF accredited chronic pain management program.

A review of the submitted EOB indicates that the respondent paid \$125.00 for the chronic pain management program based upon the medical fee guideline. The requestor disagrees and contends that additional reimbursement is due because payment was not per the medical fee guideline.

28 Texas Administrative Code §134.204(h)(1)(B) states "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."

28 Texas Administrative Code §134.204(h)(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 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."

The Division finds that the requestor billed CPT code 97799-CP for 40 hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is \$100.00 per hour (\$125.00 X 80%). \$100.00 times the 40 hours is \$4,000.00. The respondent paid \$125.00. The Division finds the requestor is due additional reimbursement of \$3,875.00.

## Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,875.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,875.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

11/10/2016

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**