



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated Healthcare

Respondent Name

Safety National Casualty Corp.

MFDR Tracking Number

M4-24-1160-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 25, 2024

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| October 31, 2023 | 97799-CP | \$400.00 | \$400.00 |
| Total | | \$400.00 | \$400.00 |

Requestor's Position

"We disagree that this bill should not be paid."

Amount in Dispute: \$400.00

Respondent's Position

The Austin carrier representative for Safety National Casualty Corp. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 30, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no position statement has been received from the insurance carrier or its

representative. However, the carrier has provided explanation of benefits and payment documentation. We will base this decision on the information available at the time of review.

Response Submitted by: N/A

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 Medical Fee Dispute Resolution requests.
2. [28 TAC §134.230](#) sets out the medical fee guidelines for Return to Work Rehabilitation Programs.

Denial Reasons

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

- 4 – The procedure code is inconsistent with the modifier used or the required modifier is missing.
- 10- The billed service requires the use of a modifier code.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. What rules apply to the service in dispute?
2. Is the insurance carrier's denial reason of the disputed service supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of \$400.00 for disputed services rendered on October 31, 2023.

A review of the submitted documentation finds that the requestor billed the insurance carrier \$400.00 for 4 units of CPT code 97799-CP on the disputed date of service.

DWC finds that 28 TAC §134.230, which sets out the fee guideline for chronic pain management services, applies to the reimbursement of CPT code 97799-CP. 28 TAC §134.230(1) 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). (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."

28 TAC §134.230(5), which applies to the billing and reimbursement of CPT code 97799-CP, 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."

2. A review of the submitted explanation of benefits (EOB) documents finds that the insurance carrier denied payment for four units of CPT code 97799-GP, based on missing or incorrect modifier appended to the procedure code that was billed. Modifier "GP" is not found on the submitted medical bills.

A review of the submitted medical bills finds that the requestor properly billed for the service of a non-CARF accredited Chronic Pain Rehabilitation Program, using CPT code 97799-CP, in accordance with 28 TAC §134.230.

DWC finds that the insurance carrier's denial reason of payment for the disputed service is not supported.

3. The requestor is seeking reimbursement in the amount of \$400.00 for 4 units of CPT code 97799-CP rendered on October 31, 2023. Because the insurance carrier's denial reason is not supported, DWC finds that the requestor is entitled to reimbursement.

A review of the submitted documentation finds:

- The requestor documented and billed for four hours of a non-CARF accredited chronic pain management program using code 97799-CP x 4 units in accordance with 28 TAC §134.230.
- Per 28 TAC §134.230(1) and (5), the following formula is used to calculate the maximum allowable reimbursement (MAR): $80\% \text{ of } \$125.00 = \$100.00 \times 4 \text{ hours} = \400.00 .

- The respondent paid \$0.00.
- DWC finds that the requestor is entitled to reimbursement in the amount of \$400.00 for the disputed date of service, October 31, 2023.

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.

DWC finds the requestor has established that reimbursement in the amount of \$400.00 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, Safety National Casualty Corp. must remit to the Requestor, Peak Integrated Healthcare, \$400.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

April 2, 2024

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, 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.tas.gov.