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**
PRIDE

**Respondent Name**
American Zurich Insurance Company

**MFDR Tracking Number**
M4-24-1828-01

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

**DWC Date Received**
April 18, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 19, 2023, through February 22, 2024 | 97799-CP-CA-GP-GO | $4,125.00 | $4,125.00 |
| March 12, 2024 | 97750-FC-GP | $670.00 | $0.00 |
| | **Total** | $4,795.00 | $4,125.00 |

## Requestor's Position

"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:** $4,795.00

## Respondents' Position

"Attached is a copy of the PLN 11 disputing the extent of injury that has been filed with the DWC as well as a copy of the peer review report supporting our position that the treatment is not related to the accepted compensable injury."

**Response Submitted by:** ESIS

## Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.230 sets out the guidelines for return-to-work rehabilitation programs.
4. 28 TAC §133.240 sets out the guidelines for the medical payments and denials.

Denial Reasons

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

- P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Does the dispute contain an unresolved extent of injury issue?
2. Is the insurance carrier's denial supported?
3. Is the requestor entitled to reimbursement for the chronic pain management services?
4. Is the functional capacity evaluation service eligible for Medical Fee Dispute Resolution review?
5. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. A review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider… related to

the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

A review of the submitted information finds insufficient documentation to support an EOB was presented to the health care provider giving notice of the extent of injury defense or denial reason prior to the filing of the MFDR.

Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240, the DWC finds the respondent has raised new denial reasons or defenses. The carrier failed to give notice to the health care provider during the medical bill review process or before the filing of this dispute. Consequently, the division concludes that the insurance carrier has waived the right to raise a new denial reason or defense during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. This dispute pertains to the non-payment of a CARF accredited chronic pain management program rendered on September 19, 2023, through February 22, 2024, and a functional capacity evaluation rendered on March 12, 2024. The disputed services were billed under CPT code 97799-CP-CA-GP-GO and 97750-FC-GP. The requestor seeks reimbursement in the amount of $4,795.00.

Using the previously mentioned denial reduction code indicated above, the insurance carrier audited and denied the services in dispute.

A review of the medical fee dispute finds that the insurance carrier submitted insufficient documentation to support the P12 (description provided above) denial reason. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

3. The requestor seeks reimbursement for CARF accredited chronic pain management services. 28 TAC §134.230 applies to the services in dispute.

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."

The requester billed 97799-CP-CA-GP-GO. The disputed services are CARF accredited, and reimbursement shall be 100% of the 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."

| DOS | CPT | Number of Units Billed | Amount Billed | Amount Paid | Amount in Dispute | Amount Due |
|---|---|---|---|---|---|---|
| September 19, 2023 | 97799-CP-CA | 6 | $960.00 | $0.00 | $750.00 | $750.00 |
| September 21, 2023 | 97799-CP-CA | 7 | $1,120.00 | $0.00 | $875.00 | $875.00 |
| October 24, 2023 | 97799-CP-CA | 5 | $800.00 | $0.00 | $625.00 | $625.00 |
| October 26, 2023 | 97799-CP-CA | 5 | $800.00 | $0.00 | $625.00 | $625.00 |
| January 30, 2024 | 97799-CP-CA | 5 | $800.00 | $0.00 | $625.00 | $625.00 |
| February 22, 2024 | 97799-CP-CA | 5 | $800.00 | $0.00 | $625.00 | $625.00 |
| | Total | 33 | $5,280.00 | $0.00 | $4,125.00 | $4,125.00 |

The DWC finds the requestor is entitled to a total reimbursement amount of $4,125.00 for the CARF accredited chronic pain management services, rendered on September 19, 2023, through February 22, 2024.

4. The requestor seeks reimbursement in the amount of $670.00, for a functional capacity evaluation, billed under CPT code 97750-FC, and rendered on March 12, 2024.

The health care provider is permitted to file for medical fee dispute resolution only after it has filed for reconsideration, per 28 TAC §133.250. If the healthcare provider has not received an explanation of benefits from the insurance carrier, and if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

Per 28 TAC §133.307 (c)(2), states, "(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include…"

Per 28 TAC §133.307 (c) (2)(J) states, "a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to

the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills)…"

The requestor did not submit a copy of a reconsideration medical bill with the DWC060 request.

Per 28 TAC §133.307 (c)(2)(K) states "each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB…"

28 TAC §133.250 (g) states that the insurance carrier's deadline to take final action and issue an explanation of benefits is 30 days from the date of receipt of the request for reconsideration. If after 35 days, there is no indication of final action from the insurance carrier, the health care provider may then file for medical fee dispute resolution.

The requestor did not include a copy of the reconsideration EOB or evidence of insurance carrier's receipt of the request for a reconsideration EOB.

Per 28 TAC §133.250. The healthcare provider has 10 months from the date of service to request a reconsideration.

The documentation submitted by the requestor does not support that a reconsideration was sought prior to the filing of the MDR.

The DWC finds that this request for medical fee dispute resolution for CPT Code 97750-FC rendered on March 12, 2024, is not eligible for review. As a result, the DWC finds that good cause exists to dismiss this charge according to 28 TAC §133.307.

5. The DWC finds that the requester is entitled to reimbursement in the amount of $4,125.00 for the chronic pain management services rendered September 19, 2023, through February 22, 2024. As a result, $4,125.00 is due.

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 requestor has established that reimbursement 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 submit to the requestor $4,125.00 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 | October 24, 2024<br>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 electronico CompConnection@tdi.texas.gov.