TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
North Texas Pain Recovery Center

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-25-0296-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 2, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 16, 2023, through November 30, 2023	97799-CP-CA CARF accredited chronic pain	$38,150.00	$875.00
	Total	$38,150.00	$875.00

Requestor's Position

"Carrier denied services rendered using the denial "unnecessary medical treatment". The carrier cannot deny services using that denial. The services are not subject to retroactive review for medical necessity. See Labor Code 413.014(e). *(e) If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service*. Enclosed is the carriers UR decisions both prospective and concurrent reviews. An order should be rendered for the carrier to pay MAR value PLUS INTEREST for the services rendered."

Amount in Dispute: $38,150.00

Respondents' Position

"Upon receipt of the MDR requested, the bill was sent for reconsideration. A payment of $5,000.00 for DOS 10-16-2023/10-20-23, $2250.00 for DOS 10-23-23/10-25-23, $2,000.00 for DOS 10-26-23/10-27-23, $4500.00 for DOS 10-30-23/11-3-23, $3500.00 for DOS 11-6-23/11-9-23, $1250.00 for DOS 11-9-23/11-10-23, $4625.00 for DOS 11-13-23/11-17-23, $750.00 for DOS 11-20-23/11-20-23 and $2500.00 for DOS 11-27-23/11-30-23, were all issued on 10-24-24. Attached are copies of the EORs for payments and the payment screens for the bill and interest payments issued"

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 return-to-work rehabilitation programs.

Denial Reasons

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

- 1 – Previous gross recommended payment amount on line: $0; Previous recommended payment amount on line: $0, Additional recommended allowance of $1000.00 is being made based upon additional supporting documentation received
- 2 – Charge exceeds Fee Schedule allowance (222)
- 3 – Chronic Pain Management Program (437)
- 4 – P12 - Workers' compensation jurisdictional fee schedule adjustment. (ANSIP12)
- 5 – Additional recommendation is based upon additional supporting documentation received. (CIQ377)
- 6 – Rush Bill (E328)
- 7 – A technical Bill Review (TBR) has been performed. (ETBR)
- 8 – Previous recommended history on DCN(s): 600542072= $0.00 (ANSI216, TX06, W9) (RE555)
- 9 – W3 - TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title. (W3)

Issues

1. Following the submission of the Medical Fee Dispute Resolution request (MFDR), did the insurance company pay for the disputed services?
2. Is the requester entitled to additional reimbursement?

Findings

1. This dispute pertains to CARF accredited chronic pain management services rendered on October 16, 2023, through November 30, 2023. The requestor seeks reimbursement in the amount of $38,150.00.

   The insurance carrier states, "Attached are copies of the EORs for payments and the payment screens for the bill and interest payments issued."

   Several payments totaling $26,375.00 were made, according to a review of the insurance carrier's explanation of benefits (EOBs). The DWC will determine whether the requestor is entitled to additional reimbursement.

2. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

   28 TAC §134.230(1)(A), (B) 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 requestor billed 97799-CP-CA; therefore, the disputed program is CARF accredited, and reimbursement shall be 100% of the MAR.

   28 TAC §134.230(5)(A), (B) 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 should 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 requestor seeks a total reimbursement of $38,150.00 for CARF accredited chronic pain management rendered on October 16, 2023, through November 30, 2023. The DWC finds that reimbursement is determined per 28 TAC §134.230(5)(A), (B) at $125.00/hour. The insurance carrier issued the following payments.

- DOS 10-16-23, 10-17-23, 10-18-23, 10-19-23, and 10-20-23, the requester is entitled to $7,250.00. The insurance carrier paid in full. Additional reimbursement is not recommended.
- DOS 10-23-23, 10-24-23, and 10-25-23, the requester is entitled to $2,250.00. The insurance carrier paid in full. Additional reimbursement is not recommended.
- DOS 10-26-23, 10-27-23, the requester is entitled to $2,000.00. The insurance carrier paid in full. Additional reimbursement is not recommended.
- DOS 10-30-23, 10-31-23, 11-1-23, 11-2-23, and 11-3-23 the requester is entitled to $4,500. 00. The insurance carrier paid in full. Additional reimbursement is not recommended.
- DOS 11-6-23, 11-7-23, 11-8-23, and 11-9-23 the requester is entitled to $3,500.00. The insurance carrier paid in full. Additional reimbursement is not recommended
- DOS 11-9-23, and 11-10-23 the requester is entitled to $1,250.00. The insurance carrier paid in full. Additional reimbursement is not recommended
- DOS 11-13-23, 11-14-23, 11-15-23, 11-16-23, and 11-17-23 the requester is entitled to $4,625.00. The insurance carrier paid in full. Additional reimbursement is not recommended
- DOS 11-20-23 the requester is entitled to $750.00. The insurance carrier paid in full. Additional reimbursement is not recommended
- DOS 11-27-23, 11-28-23, 11-29-23, and 11-30-23 the MAR is $3,375.00. The insurance carrier paid $2,500.00. The requestor is therefore entitled to an additional payment in the amount of $875.00.

The DWC finds that the requester is entitled to additional reimbursement in the amount of $875.00 for DOS 11-27-23, 11-28-23, 11-29-23, and 11-30-23. 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 requestor has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor $875.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 14, 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 electronico CompConnection@tdi.texas.gov.