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
Occufit

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-25-0452-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 24, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 30, 2024	97799-CP	$800	$800
September 3, 2024	97799-CP	$800	$800
September 4, 2024	97799-CP	$800	$800
September 5, 2024	97799-CP	$800	$800
September 6, 2024	97799-CP	$800	$800
	Total	$4,000.00	$4,000.00

Requestor's Position

"Our office did not exceed the precertification / authorization for this services/ approval states 80 hours) This seems to be an ongoing issue with Gallagher Bassett not processing claims correctly."

Amount in Dispute: $4,000.00

Respondent's Position

"The provider was billing at a rate as if it were CARF accredited. It is currently seeking reimbursement at the lesser rate of $100 per hour compared to the billed rate of $125 per hour. We are attaching a copy of the URA approval letter dated August 12, 2024. Also attached is the provider's CMS 1500 and the carrier's EOBs dated September 30, 2024 October 22, 2024. The carrier stands by his decisions as identified on its EOBs."

Response Submitted by: Flahive, Ogden & Latson

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, 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.

Denial Reasons

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

- 198 - Precertification/notification/authorization/pre-treatment exceeded.
- N54 - Claim information is inconsistent with pre-certified/authorized services.
- XXG15 - Pricing is calculated based on the medical professional fee schedule value.
- XXU05 - The billed service exceeds the UR amount authorized.
- 00663 - Reimbursement has been calculated based on the state guidelines.
- 93 - No claim level adjustment.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- TX350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP rendered on August 30, 2024, September 3, 2024, September 4, 2024, September 5, 2024, and September 6, 2024. The insurance carrier denied the charge due to "Precertification/notification/authorization/ pre-treatment exceeded".

   The requestor submitted a copy of a preauthorization letter issued by Medinsights dated August 15, 2024, preauthorizing Chronic Pain Management Program x 80 hours 97799 with a start date of August 15, 2024, and an end date of November 15, 2024.

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..."

The DWC finds that the insurance carrier submitted insufficient documentation to support that the services in dispute were rendered outside the preauthorized timeframes and that they exceeded the authorized number of units. As a result, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for the services in dispute.

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

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."

28 TAC §134.230 (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."

The requester billed 97799-CP. The disputed program is not CARF accredited, and reimbursement shall be 80% of the MAR for a recommended amount of $100.00/hour.

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $100/hour	Amount Due
08/30/24	97799-CP	8	$800	$0	$800	$800
09/03/24	97799-CP	8	$800	$0	$800	$800
09/04/24	97799-CP	8	$800	$0	$800	$800
09/05/24	97799-CP	8	$800	$0	$800	$800
09/06/24	97799-CP	8	$800	$0	$800	$800
TOTALS		40	$4,000.00	$0.00	$4,000.00	$4,000.00

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 of $4,000 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 $4,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 8, 2025
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.