Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALTA VISTA HEALTHCARE
1123 NORTH MAIN AVENUE STE 100
SAN ANTONIO TX 78212

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-3646-01

MFDR Date Received
APRIL 15, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We spoke with Aetna (Reference # 187809) and they indicated that the recommended reimbursement for the attached dates of services is $64.00 per unit, however, Chartis continues to deny our request for an adjustment… We received a referral from the patient's treating doctor to evaluate the appropriateness of a rehabilitation program… Only after all the representatives from the respective areas of the interdisciplinary team concurred on the necessity of the treatment was the patient placed into the proper rehabilitation program… Alta Vista Healthcare conformed to all CARF standards and maintains the highest level of service provision in the region. Resolution has not been feasible. Alta Vista Healthcare respectfully request full payment for the services rendered."

Amount in Dispute: $4,934.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In December 2009 Chartis made additional payments for these dates of service which we believe satisfied the dispute over CARF preauthorization. The remaining disputed amounts pertain to an interpretation of a PPO contract with Focus-Aetna Workers' Comp Access LLC contract. Our position is that proper reimbursements have been made per the provisions of the contract.""

Response Submitted by: Chartis, 4300 Alpha Rd., Ste. 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2009 April 14, 2009	CPT Codes 97545-WH-CA & 97546-WH-CA	$346.66	$0.00
April 15, 2009 through May 12, 2009	CPT Codes 97545-WH-CA & 97546-WH-CA	$4,934.95	$3,789.63

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization of certain services.
3. 28 Texas Administrative Code §134.204 sets out reimbursement guidelines for Workers' Compensation Specific Services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits:
   - 1 – (197) – Precertification/authorization absent.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - 2 – (45) – Charges exceed your contracted/legislated fee arrangement.
   - 1 – (198) – Precertification/authorization exceeded.
   - 1 – (29) – The time limit for filing has expired.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor submit the request for Medical Fee Dispute Resolution in accordance with 28 Texas Administrative Code §133.307?
3. Was date of service April 16, 2009 timely filed?
4. Was documentation submitted for date of service April 20, 2009?
5. Was preauthorization required for the services rendered to the injured employee?
6. Were the services reimbursed in accordance with the Medical Fee Guideline for Workers' Compensation Specific Services?
7. Is the requestor entitled to reimbursement?

Findings

1. On October 4, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. Although a copy of the contract was provided by the carrier, no documentation was provided to support that the carrier and respondent in this dispute notified the health care provider as specified by §133.4. The division concludes that the carrier is not entitled to pay the requestor at a contracted rate pursuant to 28 Texas Administrative Code §133.4(g); therefore, the Division fee guidelines apply pursuant to 28 Texas Administrative Code §133.4(h).
2. Per 28 Texas Administrative Code §133.307(c)(1)(A) requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B), pertaining to medical necessity, compensability or liability, of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The request for medical fee dispute resolution was received April 15, 2010. Review of the requestors Table of Disputed Services finds the dates of service April 13, 2009 and April 14, 2009 were not filed timely. Therefore, these dates of service are not eligible for review; as a result the amount ordered is $0.00.
3. On April 29, 2010, the insurance carrier denied date of service April 16, 2009 using denial code 29 – The time limit for filing has expired. Review of EOBs submitted by the insurance carrier finds that this date of service was initially processed on May 5, 2009 and reconsidered on August 27, 2009. Therefore, the carrier's denial is not supported and the services will be reviewed in accordance with Division rules and the Labor Code.
4. The Table of Disputed Service lists April 20, 2009 as one of the disputed dates of service. Review of the documentation submitted by both parties does not support that services were rendered to the injured employee on this date of service. As a result the amount ordered is $0.00
5. Review of the EOBs submitted by both parties finds that the initial and reconsideration EOBs denied the services using denial codes 1-(197) – "Precertification/authorization absent" and 1-(198) – "Precertification/authorization exceeded." The insurance carrier did not maintain these denials except for dates of service April 16, 2009, April 23, 2009, April 30, 2009, and May 1, 2009. In accordance with 28 Texas Administrative Code §134.600(a)(4) Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the Division from preauthorization and concurrent review requirements.

Review of submitted documentation finds that the health care provider was exempted from preauthorization and concurrent review for Work Hardening from March 1, 2008 thru November 30, 2010. Therefore, the insurance carrier's denial is not supported and the services will be reviewed in accordance with Division rules and the Labor Code.

6. In accordance with 28 Texas Administrative Code §134.204 (h)(1)(A) and (3)(A-B) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. Accreditation by the CARF is recommended, but not required. 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 MAR. For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.
    - CPT Code 97545-WH-CA: Dates of Service: 04/15/2009 through 05/12/2009 - 17 hrs x $128.00 ($64.00 x 2) = $2,176.00 - $1,398.13 (Carrier reimbursement) = $777.87
    - CPT Code 97546-WH-CA: Dates of Service: 04/15/2009 through 05/12/2009 - 102 hrs x $64.00 = $6,528.00 - $3,516.24 (Carrier reimbursement) = $3,011.76
7. Review of the submitted documentation finds that the requestor is due $3,789.63

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 $ 3,789.63.

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 $3,789.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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