



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

TX Health dba Injury 1 Dallas

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-13-0630-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

November 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it is our position that CCMSI has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered..."

Amount in Dispute: \$368.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the request was not complete and fails to satisfy the prerequisite for medical dispute resolution."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2012	97546WHCA	\$368.00	\$368.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out fee guidelines for medical fee guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

- Did the requestor support the position that claim was not paid per guidelines?
- Did the respondent support that request for reconsideration was incomplete?
- Is the requestor entitled to reimbursement?

Findings

- 1. 28 Texas Administrative Code §134.204 (h)(3) states, "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
 - (A) 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.
 - (B) 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."

Review of the submitted documentation finds the services in dispute were billed in compliance with above guidelines. Therefore, these services will be reviewed per applicable rules and fee guidelines.

- 2. Per 28 Texas Administrative Code §133.307(c)(2)(N)(i) states," (N) a position statement of the disputed issue(s) that shall include: (i) the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds the requestor stated in pertinent parts, "claim was paid incorrectly" and "payable at 100% of fee schedule". Therefore the Division finds the respondent's position is not supported.
- 3. Per 28 Texas Administrative Code §134.204(h)(3)(B) the services in disputed are payable at \$64 per unit or; (\$64 x 6= \$384.00). The total allowable for the disputed services is \$384.00. The carrier paid \$16.00 therefore reimbursement in the amount of \$368.00 is recommended.

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 \$3684.00

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 \$368.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April , 2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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