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
Kinetic Clinic

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-13-1273-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill previously denied for lack of preauthorization, appealed with letter of preauthorization attached. Denied again supposedly network claim, bills are been paid by the insurance company previously, medical treatment approved by Miss Keisha Mitchell adjuster 800-486-2422*41799, since the beginning of medical treatment."

Amount in Dispute: $2,560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier did not reimburse the $2,560.00 charges for work hardening as documentation was not provided to enable the carrier to properly process the charges. The Requestor has submitted additional documentation with the request for medical dispute resolution. I have forwarded the documentation to the carrier medical bill audit division to determine if the documentation provided is sufficient enough to properly process the charges, and if so, the bills will be processed and paid per the DWC Fee Guidelines."

Response submitted by: AIG, 4100 Alpha Rd., Ste 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20 – 24, 2012	97545 WC, 97546 WC	$2,560.00	$1,152.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 24 – Charges are covered under a capitation agreement/managed care plan
   - 1 – Payment for this charge is not recommended per our Utilization Management Department

- 16 – Claim/service lacks information which is needed for adjudication

Issues

1. Did the respondent support denial of the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 1 – "Payment for this charge is not recommended per our Utilization Management Department." Review of the submitted documentation finds;

    a. Health Direct, Inc – UR review/modified approval for 40 hours of a work hardening program. Begin date 08/09/2012 Expiration date: 09/23/2012.

    The carrier's denial is not supported therefore, the services in dispute will be processed per division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.202(5)(C) states, "Work Hardening/Comprehensive Occupational Rehabilitation Programs (for commission purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.) (h) 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. (1) 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 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. (2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $36 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 eight minutes and less than 23 minutes. Review of the disputed charges finds the following;

Date of Service	Submitted Code	Units	Amount billed	MAR
August 20, 2012	97545 WC	2	128.00	$36.00 x 80% = 28.80 x 2 units = $57.60
August 20, 2012	97456 WC	6	384.00	$36.00 x 80% = 28.80 x 6 units = $172.80
August 21, 2012	97545 WC	2	128.00	$36.00 x 80% = 28.80 x 2 units = $57.60
August 21, 2012	97546 WC	6	384.00	$36.00 x 80% = 28.80 x 6 units = $172.80
August 22, 2012	97545 WC	2	128.00	$36.00 x 80% = 28.80 x 2 units = $57.60
August 22, 2012	97546 WC	6	384.00	$36.00 x 80% = 28.80 x 6 units = $172.80
August 23, 2012	97545 WC	2	128.00	$36.00 x 80% = 28.80 x 2 units = $57.60
August 23, 2012	97546 WC	6	384.00	$36.00 x 80% = 28.80 x 6 units = $172.80
August 24, 2012	97545 WC	2	128.00	$36.00 x 80% = 28.80 x 2 units = $57.60
August 24, 2012	97546 WC	6	384.00	$36.00 x 80% = 28.80 x 6 units = $172.80
		TOTAL	$2,560.00	$1,152.00

3. Review of the submitted documentation finds that the total maximum allowable reimbursement is $1,152.00. The carrier previously paid $0.00. The balance of $1,152.00 is due to the requestor.

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 $1,152.00.

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 $1,152.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2014
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 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.