



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

ELITE HEALTHCARE GARLAND

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-13-2584-01

Carrier's Austin Representative Box

Box Number: 19

MFDR Date Received

JUNE 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Review of the information submitted by the requestor finds that no position summary was included in the request for medical fee dispute resolution.

Amount in Dispute: \$1,156.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I have attached bills, eob's and payment detail that we have processed to date. We have escalated the MDR for an additional review by the bill auditing company. That review is currently in process. We will supplement a response once the review has been completed."

Response Submitted by: GALLAGHER BASSETT SERVICES, INC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2012 February 6, 2012 February 15, 2012 March 20, 2012 June 4, 2012 June 5, 2012 June 6, 2012	Office Visit – CPT Code 99213 Office Visit – CPT Code 99213 Office Visit – CPT Code 99213 Office Visit & Physical Therapy Work Conditioning – CPT Code 97546-WC	\$955.06	\$0.00
June 11 - June 12, 2012 June 13 – June 18, 2012 June 19 – June 20, 2012	Work Conditioning – CPT Code 97546-WC	\$201.60	\$201.60

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 health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- W1 – Workers Compensation State Fee Schedule Adjustment.
 - W1 – This line was included in the reconsideration of this previously reviewed bill.
 - LN – This line was included in the econsideration [sic] of this previously reviewed bill.
 - BL – This bill is a reconsideration of a previously review bill. Allowance amounts do not reflect previous payments.
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
 - 15 – (150) Payer deems the information submitted does not support this level of service.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the requestor receive payment for the eligible dates of service in dispute?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. 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) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability." The requestor submitted a copy of the District Court decision. Review of the District Court decision finds that the date the decision was signed was June 8, 2012, sixty (60) days after the District Court decision is August 8, 2012. Medical Fee Dispute Resolution received the request for medical fee dispute resolution on June 10, 2013; therefore dates of service January 26, 2012 through June 6, 2012 were not submitted timely and the requestor has waived the right to Medical Fee Dispute Resolution for those dates of service.

Per 28 Texas Administrative Code §133.307(c)(1)(B) dates of service June 11, 2012 through June 20, 2012 are considered timely and eligible for review.

2. 28 Texas Administrative Code §134.204(h) states: "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."

The disputed issue is CPT Code 97546-WC. Review of the payment information submitted by the respondent finds that although they have submitted "Display Claim Payment" screens for the eligible dates of service, the payment screens do not contain a payment amount nor does it appear that these dates of service were reimbursed. Therefore the Division finds that reimbursement is due as follows:

- June 11, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour
- June 12, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour

- June 13, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour
- June 14, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour
- June 18, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour
- June 19, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour
- June 20, 2012 – CPT Code 97546-WC, \$28.80 per hour x 1 hour

Total amount of 7 Units of CPT Code 97546 x \$28.80/hour = \$201.60

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the dates of service January 26, 2012 through June 6, 2012; the Division also finds that additional reimbursement is due for dates of service June 11, 2012 through June 20, 2012. As a result, the amount ordered is \$201.60.

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 \$201.60 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	Date
		<u>May 22, 2014</u>

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.