



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Texas Health DBA Injury 1

**Respondent Name**

The Insurance Company

**MFDR Tracking Number**

M4-13-3026-01

**Carrier's Austin Representative**

Box Number 06

**MFDR Date Received**

July 15, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The Crawford Claims division has not paid for the preauthorized medical services approved for (injured worker) in accordance with applicable state law and regulations for the patient's Work Hardening and Condition Program. The claims were denied for "absence of precert/preauth" for services. Both dates of service were approved and authorized prior to services being rendered."

**Amount in Dispute:** \$2,192.32

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute request received July 23<sup>rd</sup>, 2013. However, no written position statement submitted.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2013 and February 5, 2013	97545, 97546	\$1024.00	\$1,024.00

#### 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 medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the procedures for prospective and concurrent review of health care
- 28 Texas Administrative Code §134.204 sets our fee guidelines for specific workers' compensation services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 080 – Denied per carrier
  - 193 – Original payment decision maintained
  - 197 – Payment adjusted for absence of precert/preauth

- 168 – No additional allowance recommended

**Issues**

1. Did the requestor support additional payment is due?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the services in dispute as, 197 – “Payment adjusted for absence of precert/preauth. 28 Texas Administrative Code §134.600(p) states, “Non-emergency health care requiring preauthorization includes: (4) all work hardening or work conditioning services requested by: (A) non-exempted work hardening or work conditioning programs.” Review of the submitted documentation finds;
  - a. Texas Approval Determination Notice dated January 11, 2013
    - i. 97545, work hardening 80 hours / approved
    - ii. 97546, work hardening/conding; ea add hour / approved

The Division finds the disputed services were prior authorized. The carrier’s denial is not supported. Therefore the services in dispute will be reviewed per applicable 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.) (i) The first two hours of each session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WH." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (ii) Reimbursement shall be \$64.00 per hour. Review of the carrier allowed charges finds the following;

Date of Service	Submitted Code	Units	Amount billed	MAR
January 16, 2013	97545	1	213.50	\$64.00 x 1 unit / 2 hours = \$128.00
January 16, 2013	97456	6	640.50	\$64.00 x 6 hours = \$384.00
February 5, 2013	97545	1	213.50	\$64.00 x 1 unit / 2 hours = \$128.00
February 5, 2013	97546	6	640.50	\$64.00 x 6 hours = \$384.00
	Total		1,708.00	\$1,024.00

3. Review of the submitted documentation finds that the total maximum allowable reimbursement is \$1,024.00. The carrier previously paid \$0.00. The balance of \$1,024.00 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 \$1,024.00.

***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 \$1,024.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

Peggy Miller  
Medical Fee Dispute Resolution Officer

July , 2014  
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.**