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
Texas Health DBA Injury 1

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-13-3027-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…it is our position that Bunch & Associates has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to (injured employee)."

Amount in Dispute: $2,192.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson, P.O. Box 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3 – 20, 2012	97545 WH CA, 97546 WH CA	$2,192.32	$2,192.32

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 our fee guidelines for specific workers' compensation services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 309 – Description not available

Issues

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

Findings

1. The carrier reduced payment with reason code 309 – "Description not available". 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	Amount paid
August 3, 2012	97545 WH CA	1	213.50	$64.00 x 1 unit / 2 hours = $128.00	$92.16
August 3, 2012	97456 WH CA	6	640.50	$64.00 x 6 units = $384.00	$11.52
August 7, 2012	97545 WH CA	6	640.50	$64.00 x 6 units = $384.00	$14.40
August 9, 2012	97545 WH CA	6	640.50	$64.00 x 6 units = $384.00	$14.40
August 13, 2012	97545 WH CA	6	640.50	$64.00 x 6 units = $384.00	$14.40
August 16, 2012	97545 WH CA	6	640.50	$64.00 x 6 units = $384.00	$14.40
August 20, 2012	97545 WH CA	5	553.75	$64.00 x 5 units = $320.00	$14.40
	Total		3,969.75	$2,368.00	$175.68

2. Review of the submitted documentation finds that the total maximum allowable reimbursement is $2,368.00. The carrier previously paid $175.68. The balance of $2,192.32 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 $2,192.32.

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 $2,192.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 23, 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.