



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

Ace American Insurance Co

MFDR Tracking Number

M4-13-3118-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "AUTH#1000966283."

Amount in Dispute: \$1,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written notification of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2012 through October 31, 2012	97545 WC, 97546 WC	\$1,800.00	\$1,440.00

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 §133.240 sets guidelines for medical payments and denials.
3. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for workers' compensation specific services.

Issues

1. Did the requestor comply with division rules when processing the disputed services?
2. Did the requestor support additional payment is due?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box, which was acknowledged received on August 2, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division’s former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, “If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information.” Accordingly, this decision is based on the available information.
2. The requestor submitted the following documentation;
 - a. Texas Outpatient Authorization Recommendation for Work Conditioning 5 visits per week for 2 weeks from Genex Services Inc. Start date 9-Oct-2012 end date 8-Jan-2013. Procedure(s) 97545 and 97546.
 - b. Appeal for payment showing November, 2012 certified mail receipt and April, 2013 certified mail receipts.

28 Texas Administrative Code §133.240(a) states in pertinent part, “An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier’s deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.” Review of the submitted documentation finds no documentation to support the respondent took final action in required time frame of the Division therefore, the services in dispute will be processed per division rules and fee guidelines.

3. 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
October 17, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 17, 2012	97456 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 18, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 18, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 19, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 19, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 22,2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 22, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 23, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60

October 23, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 25, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 25, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 26, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 26, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 29, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 29, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 30, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 30, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
October 31, 2012	97545 WC	2	72.00	\$36.00 x 80% = 28.80 x 2 units = \$57.60
October 31, 2012	97546 WC	3	108.00	\$36.00 x 80% = 28.80 x 3 units = \$86.40
		TOTAL	\$1,800.00	\$1,440.00

4. Review of the submitted documentation finds that the total maximum allowable reimbursement is \$1,440.00. The carrier previously paid \$0.00. The balance of \$1,440.00 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 \$1,440.00.

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 \$1,440.00 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

August , 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.