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 FORT WORTH

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-14-0196-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated September 16, 2013: "I have tried to get these claims paid without any success. Claims before and after these dates of service have been paid 100%. Office visits are recommended as determined to be medically necessary. Carrier shall not withdraw a preauthorization or concurrent review approval once issued."

Requestor's Position Summary dated October 16, 2013: "In response to the fax that I received regarding this dispute that I filed for this patient. Patient had authorization for 10 days for 8 hours a day for the work hardening program. Visit 8 of 10, DOS 5.1.2013 was not paid for, plus the office visit for that was not either. But the work status form was, cannot do that. Have to have office visit in conjunction with work status form. That is contradicting. And then on DOS 5.16.2013, denial that was received stated that the modifier was inconsistent. Which is also incorrect, modifier that was billed with visit is 25. Please take a closer look at copies of the denials that was sent in with the dispute."

Requestor's Position Summary dated October 25, 2013: "This is an approved case and these services that I'm disputing shall be paid in full. All other claims have been paid in full. Our office has not received payment for these dates of services that I'm disputing. Patient had authorization for services. Therefore, this dispute should be paid in full."

Amount in Dispute: $642.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it 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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2013 May 16, 2013	CPT Code 99213-25 Office Visit	$116.39/ea	$0.00
May 1, 2013	CPT Code 97545-WH (2 hours) Work Hardening	$102.40	$102.40
	CPT Code 97546-WH (6 hours) Work Hardening	$307.20	$307.20
TOTAL		$642.38	$409.60

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 resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim service lacks information which is needed for adjudication.
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.

Issues

1. Does the documentation support billing office visit, CPT code 99213-25?
2. Does the documentation support billing work hardening program, CPT codes 97545-Wh and 97546-WH?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the May 1, 2013 office visit based upon reason code "16", and the May 16, 2013 one based upon reason code "4".

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   The requestor appended modifier "25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service" to code 99213.

   The requestor contends that reimbursement is due because "Visit 8 of 10, DOS 5.1.2013 was not paid for, plus the office visit for that was not either. But the work status form was, cannot do that. Have to have office visit in conjunction with work status form. That is contradicting." Although the information obtained from the office visit was used to complete the work status report, the requestor must document the level of office billed. A review of the submitted medical report finds that the requestor did not document two of the three key components required for CPT code 99213. As a result, reimbursement is not recommended.

2. The respondent reduced payment for the work hardening program based upon reason code "16."

   The requestor states that "Patient had authorization for 10 days for 8 hours a day for the work hardening program. Visit 8 of 10, DOS 5.1.2013 was not paid for."

   The issue in dispute is not preauthorization but whether the documentation supports the level of service billed.

   28 Texas Administrative Code §134.204(h)(1)(B) states "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."

   28 Texas Administrative Code §134.204(h)(3)(A) and (B) states "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $64 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 8 minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97545WH and 97546WH for eight hours. A review of the submitted **Work Hardening PROGRESS REPORT** finds that the requestor noted that claimant attended 8 hours of work hardening on May 1, 2013 and May 2, 2013. According to the explanation of benefits, the respondent paid for the May 2, 2013 work hardening services but not May 1, 2013. Because the information is identical for both dates, the respondent's denial is inconsistent and not supported. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (3)(A) and (B), the MAR for a non-CARF accredited program is $51.20 per hour ($64.00 X 80%). $51.20 times the 8 hours billed is $409.60. The respondent paid $0.00. The difference between the MAR and amount paid is $409.60. This amount is recommended for additional reimbursement.

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 $409.60.

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 $409.60 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	05/14/2015 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.