



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 of Dallas

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-14-0616-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 21, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it is our position that CCMSI has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered..."

Amount in Dispute: \$886.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no written position submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12 through May 30, 2013	Work Hardening	\$886.00	\$468.96

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 out guidelines for medical payments and denials.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.204 sets out Medical Fee Guideline for Workers' Compensation Specific Services
5. No explanation of benefits was sent with request for medical fee dispute.

Issues

1. Did the requestor support claim submission was complete and timely?
2. Does the submitted documentation support level of services billed?
3. Is the requestor entitled to reimbursement?

Findings

- 28 Texas Administrative Code §133.240(a) states, “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 that;

- Submitted claim form indicates CCMSI, 13601 Preston Rd, Suite 313 West, Dallas, TX 75240
- Submission dates in 31-B of claim form were 3/12/13, 3/22/13, 4/9/13, 4/10/13, 4/24/13, 4/26/13, 5/14/13, 5/30/13
- Claims faxed to carrier May 17, 2013, July 11, 2013, September 3, 2013

No position from carrier submitted to dispute information supporting timely submission of clean claims.

- Requestor submitted code 99367, “Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present.” 28 Texas Administrative Code §134.204 (e)(2) states in pertinent part, “Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.” Review of the submitted documentation did not support a change in the condition of the injured worked. Requirements of Division guidelines not met, no reimbursement can be recommended. The remaining services will be reviewed per applicable rules and fee guidelines.
- 28 Texas Administrative Code 133.203(c) 1 is applicable fee schedule calculation for Professional Service code, “96151”. 28 Texas Administrative Code §134.204(h)(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.
 - 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.
 - 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 Maximum Allowable Reimbursement for work conditioning is calculated below:

Date of Service	Submitted Code	Submitted Charge	Units	Maximum Reimbursement Allowable
March 12, 2013	99367	\$50.00	1	N/A not supported
March 22, 2013	97545 WH CA	\$213.50	1	\$36 x 2 = \$72.00
April 9, 2013	99367	\$50.00	1	N/A not supported
April 10, 2013	97545 WH CA	\$213.50	1	\$36 x 2 = \$72.00
April 24, 2013	97545 WH CA	\$213.50	1	\$36 x 2 = \$72.00
April 24, 2013	97546 WH CA	\$133.44	1.25	\$36 x 1 = \$36 + 36 ÷ 4 = 9 x 1 = \$9.00 \$36 + \$9 = \$45.00
April 26, 2013	97545	\$213.50	1	\$36 x 2 = \$72.00
April 26, 2013	97546	\$26.69	.25	36 ÷ 4 = 9 x 1 = \$9.00
May 14, 2013	99367	\$50.00	1	N/A not supported
May 30, 2013	96151	\$140.00	4	(TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or: (55.3 / 34.023) x 19.53 = \$31.74 x 4 = \$126.96
			TOTAL	\$468.96

- The total allowable for the reviewed services is \$468.96. The carrier previously paid \$0.00. The remaining balance of \$468.96 is recommended.

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 \$468.96.

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 \$468.96 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	April 2, 2014 Date
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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.