



# 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**

RICHARD ALEXANDER, D.C.

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-14-1690-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

FEBRUARY 10, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "[Claimant] was in a Work Hardening Program which each Daily Session he was performing the program for 8 hours per session. He did perform all exercises at a slower pace. His low back would frequently spasm on him in the middle of the day and his pain levels were elevated. This would further slow his pace. There is no rule in the ODG Guidelines which states that a patient in a Work Hardening Program has to perform all of his/her exercises/activities at a given speed. Some patients do perform their exercises/activities at a faster pace, some perform at a slower pace. This depends upon the degree of injury, patient's pain levels, patient's functional abilities, etc."

**Amount in Dispute:** \$1,280.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Requestor is not entitled to further reimbursement. Although Requestor billed for an additional 6 hours of work hardening (in addition to the initial 2 hours) each day, the actual records of treatment do not reflect provision of 8 hours of work hardening activities. A review of the records shows, at best, 6 hours of work hardening treatment. See attached treatment records. Thus, with reimbursement of 4 additional hours of work hardening (4 hours X \$64 per hour = \$256 per date of service), Requestor has been reimbursed all to which it is entitled for CPT Code 97546."

**Response Submitted by:** Adami, Shuffield, Scheihing & Burns

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2013 through March 5, 2013	CPT Code 97545-WH Work Hardening (2 hours per day X 10 days = 20 hours)	\$0.00	\$0.00
	CPT Code 97546-WH Work Hardening (6 hours per day X 10 days = 60 hours)	\$128.00 X 10 = \$1,280.00	\$512.00
TOTAL		\$1,280.00	\$512.00

## ***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 §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1-Workers compensation state fee schedule adjustment.
  - 309-The charges for this procedure exceeds the fee schedule allowance.
  - 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
  - OA-The amount adjusted is due to bundling or unbundling of services.
  - W3-Additional payment made on appeal/reconsideration.

### **Issues**

1. Did the respondent file the response in the form and manner required by 28 Texas Administrative Code §133.307?
2. Did the requestor exceed the number of work hardening units allowed?
3. Is the requestor entitled to additional reimbursement for the work hardening program rendered from February 20, 2013 through March 5, 2013?

### **Findings**

1. The respondent states in the position summary that "the actual records of treatment do not reflect provision of 8 hours of work hardening activities."

28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

A review of the submitted explanation of benefits finds that the respondent did not raise the issue of documentation prior to medical fee dispute resolution. The Division concludes that the respondent did not file the response in the manner required by 28 Texas Administrative Code §133.307(d)(2)(F). As a result, the documentation issue will not be considered further in this decision.

2. The respondent denied reimbursement for the disputed work hardening program based upon reason code "600."

The requestor submitted a copy of the February 12, 2013 preauthorization report approving 80 units of work hardening, CPT codes 97545 and 97546. A review of the submitted billing finds that the requestor billed for 80 hours of work hardening, CPT codes 97545 and 97546. The Division concludes that the respondent's denial based upon reason code "600" is not supported.

3. The issue in dispute is whether the payment was in accordance with the Division fee guideline, and if additional reimbursement is due.

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 without the "CA" modifier. 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%). The requestor billed for 20 hours of code 97545-WH that is not in dispute, and 60 hours of 97546-WH in dispute. \$51.20 times the 60 hours billed for 97546-WH is \$3,072.00. The requestor indicated on the *Table of Disputed Services* that the respondent paid \$2,560.00. The difference between the MAR and amount paid is \$512.00. 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 \$512.00.

### **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 \$512.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	07/03/2014
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.**