



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

TX HEALTH DBA INJURY 1 - DALLAS

Respondent Name

FREESTONE INSURANCE CO

MFDR Tracking Number

M4-14-2880-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MAY 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was approved for the Work Hardening Program. The service was provided and the claim was paid incorrectly. CPT code 97546WHCA was billed at 4.5 units but only 4 units were paid. Please refer to the attached CMS-1500 in box #24G for further review."

Amount in Dispute: \$32.00

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
December 5, 2013	CPT Code 97546-WH (4.5 hours) Work Hardening	\$32.00	\$32.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1-Workers compensation state fee schedule adjustment.
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 247-A payment or denial has already been recommended for this service.

Issues

Is the requestor entitled to additional reimbursement for the work hardening program rendered on December 5, 2013?

Findings

The respondent reduced payment for the work hardening program based upon reason codes "W1 and 309."

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)(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 97546WHCA for 4.5 units. Therefore, per 28 Texas Administrative Code §134.204(h)(3)(A) and (B), the MAR for a CARF accredited program is \$64.00 per hour times the 4.5 hours billed is \$288.00. The respondent paid \$256.00. The difference between the MAR and amount paid is \$32.00. 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 \$32.00.

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 \$32.00 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

07/25/2014
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.