



# 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**

PAIN & RECOVERY CLINIC NORTH

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-15-0074-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

September 08, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Our facility has been struggling to get the carrier and the adjuster on file to understand the medical treatment authorized and performed on this patient. As a result we have no other choice than to pursue our administrative remedy of filing for MDR.

[Injured employee] original injury was injury to the hand, for the [date of injury], [claim number]. The carrier is denying charges for no pre-authorization.

The facility recognizes that the compensable diagnosis extends to SP/ST hand (842.01) which was the diagnosis used on the request for reconsideration. The carrier has denied our reconsideration due to the payment denied for absence of precertification/authorization.

Carrier has FAILED to recognized that the program AUTHORIZED by their utilization review department (COVENTRY) is a Work Hardening Program program. See attached pre-authorization letter, which is certified for [claim number], Approval #'s 10105251.

**Amount in Dispute:** \$1,228.80

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOBs. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, 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
November 08, 2013; November 15, 2013; November 18, 2013; November 19, 2013; November 21, 2013 and November 22, 2013	Work Hardening	\$1,228.80	\$1,228.80

## **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 §134.600 sets out the preauthorization requirements.
3. 28 Texas Administrative Code §134.204 adopted to be effective March 1, 2008, 33 TexReg 364, sets out the reimbursement for workers' compensation specific codes, services and programs provided in the Texas workers' compensation system.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 39 – Services denied a the time authorization/pre-certification was requested
  - BL – To avoid duplicate bill denial. For all recon/adjustments/additional pymnt requests, submit a copy of this EOR for clear notation that a rec
  - W3 – Request for reconsideration
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

### **Issues**

1. Did the requestor obtain preauthorization for the disputed work hardening program?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. Per 28 Texas Administrative Code §134.600, the requestor submitted a copy of a preauthorization letter (claim # 001437-035562-WC-01) supporting preauthorization was obtained for the disputed dates of service, November 8, 2013; November 15, 2013; November 18, 2013; November 19, 2013; November 21, 2013 and November 22, 2013. Therefore, the disputed charges are not subject to retrospective review and will be reviewed according to the applicable fee guidelines.

Review of the preauthorization letter dated October 09, 2013 finds Coventry Workers' Comp Services, preauthorized work hardening for eighty hours starting October 04, 2013 to December 31, 2013. Review of the submitted documentation by the requestor supports work hardening program was provided on November 08, 2013; November 15, 2013; November 18, 2013; November 19, 2013; November 21, 2013 and November 22, 2013, within the preauthorization timeframe.

2. Per 28 Texas Administrative Code §134.204(h)(3)(A-B) (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."

Per 28 Administrative Code §134.204(h)(1)(B) states in pertinent part "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."

- The requestor billed 28 hours for work hardening however, only documents 24 hours of work hardening program
- Review of the submitted documentation finds the requestor is not CARF accredited
- Requestor billed with CPT code 97545 with modifier WH with one unit for the first two hours of each session for disputed service November 08, 2013; November 15, 2013; November 18, 2013; November 19, 2013; November 21, 2013 and November 22, 2013 also billed CPT Code 97546 with modifier WH with two units for each additional hour for disputed service November 08, 2013; November 15, 2013; November 18, 2013; November 19, 2013; November 21, 2013 and November 22, 2013
- Per submitted documentation provided by the requestor finds reimbursement is due; 24 hours as documented x \$64.00 per hour equals \$1,536.00 multiplied by 80% of the MAR is \$1,228.80

Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of \$1,228.80.

**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 \$1,228.80.

**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 \$1,228.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

		4/30/15
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.**