



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

Wolmed Medical PA

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-15-0497-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

October 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Occupational rehabilitation facilities with current accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) are eligible for exemption from preauthorization and concurrent review requirements for work conditioning and work hardening if the following two conditions are met: 1. The service is within the recommendations of the Texas Division of Workers' Compensation (DWC) adopted treatment guidelines, ODG – Treatment in Workers' Comp, for the specific diagnosis, and 2. The CARF accredited facility is on the DWC current exemption list."

Amount in Dispute: \$1,280.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Due to the criteria not being met for the dates in dispute, the Office maintains that preauthorization would have needed to be requested to establish continued necessity for the Work Hardening program beyond the 20 sessions which complete on 11/6/2013."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6 – 13, 2013	97545-WH,CA 97546-WH, CA	\$1,280.00	\$1,024.00

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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.204 sets out medical fee guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment denied/reduced for absence of precertification/preauthorization

- W4 – Workers’ compensation medical treatment guideline adjustment

Issues

1. Was prior authorization required for services in dispute?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 197 – “Payment denied/reduced for absence of precertification/preauthorization.” Per 28 Texas Administrative Code §134.600(p)(12) states “Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner’s adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier.” Review of the ODG Guidelines, Shoulder, Work conditioning, work hardening finds;
 - a. (19) *Program timelines*: “These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks).”
 - b. Review of the medical bills finds the dates of service and total units as;

Date of Service	Hours
October 9, 2013	8
October 10, 2013	8
October 11, 2013	8
October 14, 2013	4
October 16, 2013	4
October 17, 2013	8
October 18, 2013	8
October 21, 2013	8
October 22, 2013	8
October 23, 2013	8
October 24, 2013	8
October 25, 2013	4
October 28, 2013	8
October 29, 2013	8
October 30, 2013	8
October 31, 2013	8
November 1, 2013	8
November 4, 2013	8
November 5, 2013	8
November 6, 2013	4
November 11, 2013	4
November 12, 2013	8
November 13, 2013	4
Total	160 hours

- c. The carrier stated in their position statement, “...preauthorization would have needed to be requested to establish continued necessity for the Work Hardening program beyond the 20 sessions which complete on 11/6/2013.” Per ODG guidelines, “The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks).” As the requestor did not exceed 20-full day visits but rather submitted 160 hours, the Division finds ODG guidelines were not exceeded.
- d. The carrier’s denial is not supported. The services in dispute will be reviewed per applicable

rules and fee guidelines.

2. Per 134.204(h)(1) states in pertinent part, "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. (3) 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..." The disputed services will be calculated as follows;

Date of Service	Submitted Code	Units	Billed Amount	Maximum Allowable Reimbursement
November 6, 2013	97545 WH CA	1	250.00	\$64 x 1 = \$64.00
November 6, 2013	97546 WH CA	2	250.00	\$64 x 2 = \$128.00
November 11, 2013	97545 WH CA	1	250.00	\$64 x 1 = \$64.00
November 11, 2013	97546 WH CA	2	250.00	\$64 x 2 = \$128.00
November 12, 2013	97545 WH CA	1	250.00	\$64 x 1 = \$64.00
November 12, 2013	97546 WH CA	6	750.00	\$64 x 6 = \$384.00
November 13, 2013	97545 WH CA	1	250.00	\$64 x 1 = \$64.00
November 13, 2013	97546 WH CA	2	250.00	\$64 x 2 = \$128.00
		Total	\$2,500.00	\$1,024.00

3. The total recommended payment for the services in dispute is \$1,024.00. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$1,024.00. This amount 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 \$1,024.00

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 \$1,024.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Peggy Miller
Medical Fee Dispute Resolution Officer

February 17, 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.