



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Elite Healthcare Fort Worth

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-0823-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has authorization for work hardening program with our office."

Amount in Dispute: \$882.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...we have escalated the bills in question for manual review to determine if additional monies are owed." As of August 14, 2015, no further response was received. Therefore, the dispute will be reviewed with the information available.

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2 & 23, 2014	Work Hardening (99456)	\$716.80	\$614.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §133.240 sets out the procedures for payment or denial of medical bills.
- 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P1 – Not defined as required in 28 Texas Administrative Code §133.240. This code is defined in the ASC X12 External Code Source 139 as "State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only."

- P12 – Not defined as required in 28 Texas Administrative Code §133.240. This code is defined in the ASC X12 External Code Source 139 as “Workers' compensation jurisdictional fee schedule adjustment.”
- W3 – Request for reconsideration.
- 193 – Not defined as required in 28 Texas Administrative Code §133.240. This code is defined in the ASC X12 External Code Source 139 as “Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.”

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The provider verbally notified the Division that they were withdrawing the requested dispute for date of service May 6, 2014. Therefore, this date of service will not be considered.

The insurance carrier denied disputed fees for dates of service July 2 and 23, 2014 with claim adjustment reason code P12, which is defined in the ASC X12 External Code Source 139 as “Workers' compensation jurisdictional fee schedule adjustment.” The disputed services involve fees for a work hardening program provided by the requestor. Billing for work hardening programs is defined in 28 Texas Administrative Code §134.204 (h)(3)(A), which states, in relevant part, “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.’”

Review of the submitted information for July 2, 2014 finds that the requestor billed one line item using CPT Code 97546-WH, one unit, and one line item using CPT Code 97546-WH, 6 units. Submitted documentation supports that this date of service consisted of a total of hours for the session. Therefore, the insurance carrier’s denial is supported for the line item using CPT Code 97546-WH, one unit, as it was not billed in accordance with 28 Texas Administrative Code §134.204 (h)(3)(A). However, the insurance carrier’s denial of the line item using CPT Code 97546-WH, 6 units is not supported and will be reviewed per applicable Division fee guidelines.

Review of the submitted information for July 23, 2014 finds that the requestor billed one line item using CPT Code 97546-WH, one unit, and one line item using CPT Code 97546-WH, 6 units. Submitted documentation supports that this date of service consisted of a total of hours for the session. Therefore, the insurance carrier’s denial is supported for the line item using CPT Code 97546-WH, one unit, as it was not billed in accordance with 28 Texas Administrative Code §134.204 (h)(3)(A). However, the insurance carrier’s denial of the line item using CPT Code 97546-WH, 6 units is not supported and will be reviewed per applicable Division fee guidelines.

2. 28 Texas Administrative Code §134.204 (h)(3)(B) states, “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.” In addition, 28 Texas Administrative Code §134.204 (h)(1) states:

(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.

(B) 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 billed codes did not include modifier “CA.” Therefore the MAR for July 2, 2014 is \$307.20 and the MAR for July 23, 2014 is \$307.20.

3. The total MAR for the services in dispute is \$614.40. The insurance carrier paid \$0.00. Therefore, an additional reimbursement of \$614.40 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 \$614.40.

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 \$614.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>August 14, 2015</u>
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, 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 MFDR 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.