



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

Texas Health/Injury 1 of Dallas

Respondent Name

FedEx Ground Package System, Inc.

MFDR Tracking Number

M4-15-3731-01

Carrier's Austin Representative

Box Number 22

MFDR Date Received

July 14, 2015

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 denied per EOB unnecessary treatment based on peer review. CPT codes 97545 WHCA & 97546 WHCA were preauthorized, **IRO Case #71690** therefore it is deemed medically necessary."

Amount in Dispute: \$3360.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed the request and determined that payment has already been made."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24 – October 10, 2014	Work Hardening	\$3360.00	\$288.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Prior to MFDR submission:
 - D73 – Services denied at the time authorization/precertification was requested.
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.

Subsequent to MFDR submission:

- A19 – Upon further review, additional payment is warranted.
- A89 – This service has been approved per claim representative.
- W1 – Workers’ compensation jurisdictional fee schedule adjustment.

Issues

1. What are the services in dispute?
2. Does a preauthorization issue exist for this dispute?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The Medical Fee Dispute Resolution Request (DWC060) includes dates of service September 24, 25, 26, and 30, 2014; and October 1, 2, 9, and 10, 2014; with CPT codes 97545-WH-CA and 97546-WH-CA. On October 21, 2015, the requestor confirmed that the insurance carrier has subsequently paid all dates of service in full, with the exception of September 30, 2014. Therefore, this is the only date of service that remains in question for this dispute.
2. On the Explanation of Benefits dated October 16, 2014, the insurance carrier denied the disputed services with claim adjustment code D73 – “SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED.” The insurance carrier did not maintain this denial on subsequent review and paid the services in part. Therefore, the Division finds that a preauthorization issue does not exist for this dispute.
3. 28 Texas Administrative Code §134.204 (h)(3) 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.

Review of the submitted documentation finds that the requestor documented eight hours of work hardening performed on the date of service. The billing reflects this with CPT code 97545-WH-CA for 1 unit and CPT code 97546-WH-CA for 6 units. The requestor indicated that they are a CARF accredited Program with the use of the modifier “CA,” and therefore, subject to 100% of MAR in accordance with 28 Texas Administrative Code §134.204 (h)(1)(A). The total MAR for the disputed services on September 30, 2014 is \$512.00.

4. The total MAR for the disputed services is \$512.00. The insurance carrier paid \$224.00. A reimbursement of \$288.00 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 \$288.00.

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 \$288.00 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>October 23, 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.