



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

DC Rehab Center

Respondent Name

Seabright Insurance Company

MFDR Tracking Number

M4-16-0063-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In looking at the explanation of reviews it appears that there has been an error in the bill reductions and total allowance. According to all of the explanation of reviews ... \$307.20 was the reduction and the allowance was \$76.80. This should be the exact opposite. In other words the total allowance should be \$307.20 ..."

Amount in Dispute: \$5068.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 17, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28 – December 23, 2014	Work Hardening Program	\$5068.80	\$3148.80

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 §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:
 - 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
 - 306 – To reprice this code requires the appropriate modifier. Please attach the appropriate modifier and resubmit.
 - 224 – Duplicate charge.
 - 446 – This add-on code has been denied as the principal procedure was not billed.

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 insurance carrier denied disputed date of service November 11, 2014 in part with claim adjustment reason code 306 – "TO REPRICE THIS CODE REQUIRES THE APPROPRIATE MODIFIER. PLEASE ATTACH THE APPROPRIATE MODIFIER AND RESUBMIT." 28 Texas Administrative Code §134.204 (h)(3)(A) requires that "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."

Review of the submitted information finds that the CMS-1500 for date of service November 11, 2014 includes disputed CPT code 97456 with modifier WH. Submitted documentation does not support that the program is CARF accredited. The insurance carrier's denial of this date of service for this reason is not supported.

The insurance carrier denied disputed date of service December 11, 2014 in part with claim adjustment reason code 446 – "THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED." 28 Texas Administrative Code §134.204 (h)(3)(A) requires that "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."

Review of the submitted information finds that the CMS-1500 for date of service December 11, 2014 includes CPT code 97545 with modifier WH and disputed CPT code 97456 with modifier WH. The insurance carrier's denial of this date of service for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 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 submitted documentation supports a reported total time of 6 hours and 15 minutes for each disputed date of service. Reimbursement for the first two hours of each date of service will not be considered, as these services were not included on the Medical Fee Dispute Resolution Request (DWC060). The MAR for the subsequent 4 hours and 15 minutes is \$272.00.

28 Texas Administrative Code §134.204 (h)(1) states,

Accreditation by the CARF is recommended, but not required.

- (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.

Submitted documentation does not support that the program in question is CARF accredited. Therefore, the total reimbursement for the disputed services is \$217.60 for each date of service in dispute. See below for the detailed analysis:

Date of service	CPT Code	Documented Time	\$134.204 (h)(1)	Paid	Due
10/28/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
10/29/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
10/30/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/4/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/5/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/6/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/10/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/11/14	97546-WH	4 hrs, 15 min	\$217.60	\$0.00	\$217.60
11/18/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/20/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
11/25/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/2/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/4/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/10/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/11/14	97546-WH	4 hrs, 15 min	\$217.60	\$102.40	\$115.20
12/12/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/15/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/16/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/17/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/18/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/22/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
12/23/14	97546-WH	4 hrs, 15 min	\$217.60	\$76.80	\$140.80
Total			\$4787.20	\$1638.40	\$3148.80

3. The total reimbursement amount for the disputed services is \$4787.20. The insurance carrier paid \$1638.40. An additional reimbursement of \$3148.80 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 \$3148.80.

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 \$3148.80 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>November 6, 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.