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
Gary Erler, D.C.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-16-0850-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 30, 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 with peer review. CPT codes 97545 WHCA & 97546 WHCA were preauthorized, **#11028490 & #11059383** therefore it is deemed medically necessary."

Amount in Dispute: $4608.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the charges for dates of service 11/7/2014 to 1/21/2015 are not related to the compensable injury. Attached is a copy of a peer review obtained which indicates the work hardening was preauthorized due to general decondition and cannot be attributed to the compensable injury."

Response Submitted by: ACE/ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20 – August 28, 2015	Work Hardening	$4608.00	$4608.00

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 §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Duplicate claim/service

- W-9 – Unnecessary treatment with peer review

Issues

1. Does an extent of injury/relatedness issue exist for this dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. In their position statement, the insurance carrier states that the services in dispute "cannot be attributed to the compensable injury." In addition, the insurance carrier submitted explanations of benefits dated December 10, 2015 for the dates of service in question, which included claim adjustment reason codes 219 – "Based on extent of injury," and W-12 – "CHARGE UNRELATED TO THE COMPENSABLE INJURY."

   28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   The submitted documentation does not support that denials for extent of injury or relatedness were presented to the requestor prior to the date the request for MFDR was filed. Therefore, these issues will not be considered for this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code W-9 – "UNCESSSARY TREATMENT WITH PEER REVIEW." 28 Texas Administrative Code §134.240(b) states, in relevant part,

   > For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, **the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized** [emphasis added] or voluntarily certified under Chapter 134 of this title.

   Review of the submitted information finds that the disputed services were preauthorized on June 30, 2015 and August 14, 2015. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. The disputed services are subject to the fee guidelines in 28 Texas Administrative Code §134.204(h), which state,

   > The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs…
   > (1) 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…
   > (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. 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.

   The MAR for the disputed services is calculated as follows:

Date of Service	CPT Code	Units	MAR
July 20, 2015	97545-WH-CA	1	$128.00
July 20, 2105	97546-WH-CA	6	$384.00
July 23, 2015	97545-WH-CA	1	$128.00
July 23, 2015	97546-WH-CA	6	$384.00
July 27, 2015	97545-WH-CA	1	$128.00
July 27, 2015	97546-WH-CA	6	$384.00
July 28, 2015	97545-WH-CA	1	$128.00
July 28, 2015	97546-WH-CA	6	$384.00
July 29, 2015	97545-WH-CA	1	$128.00
July 29, 2015	97546-WH-CA	6	$384.00
July 31, 2015	97545-WH-CA	1	$128.00
July 31, 2015	97546-WH-CA	6	$384.00
August 3, 2015	97545-WH-CA	1	$128.00
August 3, 2015	97546-WH-CA	6	$384.00
August 21, 2015	97545-WH-CA	1	$128.00
August 21, 2015	97546-WH-CA	6	$384.00
August 28, 2015	97545-WH-CA	1	$128.00
August 28, 2015	97546-WH-CA	6	$384.00
		Total:	$4608.00

4. The total MAR for the disputed services is $4608.00. The insurance carrier paid $0.00. Reimbursement of $4608.00 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 $4608.00.

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 $4608.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 30, 2015
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.