



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

ULTIMATE PAIN SOLUTIONS

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-16-1937-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

MARCH 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am in receipt of an EOB which date of service was denied with code X817. I have do not agree with this determination since 1 hour of psychological treatment is part of the work hardening program."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed code, 97799 is for an Unlisted Physical Medical Service. It is the code used with modifier CP in TX for Chronic Pain Management Programs. The modifier WH in TX is used with code 97545 or 97546 to denote a Working Hardening Program. Code 97799 with modifier WH is not appropriate for either program. There was a request for preauthorization for 10 units of Work Hardening which were completed, billed and paid. There was also a request for preauthorization of 10 units of Pain Management that would have begun on 12/23/15 but the request for preauthorization was denied. After appeal, it was approved to begin on 1/20/2016."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2015	CPT Code 97799-WH	\$350.00	\$0.00

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 §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - X817-This procedure is mutually exclusive to another procedure on this bill. By Clinical Practice Standards, this procedure should not/cannot be performed in the same treatment period.

- 193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed.

Issues

Does the documentation support billing CPT code 97799-WH? Is the requestor entitled to reimbursement?

Findings

On the disputed date of service, the requestor billed CPT code 97799-WH for one (1) unit at \$350.00.

CPT code 97799 is defined as "Unlisted physical medicine/rehabilitation service or procedure."

The requestor appended modifier "WH" to code 97799.

Per 28 Texas Administrative Code §134.204(n)(17) "WH-Work Hardening--This modifier shall be added to CPT Code 97545 to indicate work hardening was performed."

The respondent denied reimbursement based upon "The billed code, 97799 is for an Unlisted Physical Medical Service. It is the code used with modifier CP in TX for Chronic Pain Management Programs. The modifier WH in TX is used with code 97545 or 97546 to denote a Working Hardening Program. Code 97799 with modifier WH is not appropriate for either program."

28 Texas Administrative Code §134.204(h)(3)(A) 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."

The requestor indicated that "I have do not agree with this determination since 1 hour of psychological treatment is part of the work hardening program."

A review of 28 Texas Administrative Code §134.204 does not provide for billing code 97799 with the WH modifier in any circumstance; therefore, the Division finds that the requestor did not bill for the work hardening program in accordance with 28 Texas Administrative Code §134.204(h)(3)(A). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

03/31/2016

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.