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
Pain and Recovery Clinic

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-19-0423-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were authorized by the precertification department of Broadspire upon peer review. The carrier never made us aware of a PLN-11 and our bills were submitted according to TDI rules and regulations."

Amount in Dispute: $252.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it is past the filing deadline for MFDR for dates of service 9/11/17 to 9/20/17."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2017	97545 -WC CA 97546 -WC CA	$72.00 $72.00	$144.00
September 20, 2017	97545 -WC CA 97546 -WC CA	$72.00 $36.00	$108.00

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 reimbursement guidelines for workers compensation specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D10-The time limit for filing has expired

- D53 – Extent of injury not finally adjudicated

Issues

1. Was the request for MFDR submitted timely?
2. Is the insurance carrier's reason for denial supported?
3. What rule is applicable to reimbursement?

Findings

1. The respondent states, "The carrier asserts that it is past the filing deadline for MFDR for dates of service 9/11/17 to 9/20/17."

   The DWC's Commissioner issued Bulletin # B-0020-17 which states in pertinent part,

   > "For system participants who reside in the counties listed in the Governor's disaster proclamation, the Texas workers' compensation deadlines for the following procedures are tolled through the duration of the Governor's disaster proclamation:
   >
   > - Workers' compensation claim notification and filing deadlines.
   > - Medical billing deadlines.
   > - Medical and income benefit payment deadlines
   > - Electronic date reporting deadlines, and
   > - Medial and income benefit dispute deadlines

   Review of the submitted medical bill found the zip code of 77076, Harris County. This county is found within the "Proclamation by the Governor of the State of Texas" disaster declaration. The toll period began on Wednesday, August 23, 2017. The request for MFDR was received September 26, 2018. Counting resumed January 10, 2018. The toll period is 241 which is less than 365 (one year). The requestor has not waived their right to MFDR. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The requestor is seeking $252.00 for professional medical services rendered September 11, 2017 and September 20, 2017. The insurance carrier denied disputed services with claim adjustment reason code D-10 "The time limit for filing has expired and D53 – "Extent of injury not finally adjudicated."

   As stated above the health care provider is within the governor's disaster declaration area. The beginning of the tolling of the filing deadline was August 23, 2017. The date of service was September 11, 2017 and September 20, 2017. Counting began again on January 10, 2018. The tolled period is less than 45 days. The carrier's denial is not supported.

   Rule 133.307 (d)(2)(H) states that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

   Not only did the carrier fail to provide the PLN-11 to support its denial, Division records finds that the carrier failed to file the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) to the Division prior to or concurrent with the date that it took final action on this medical bill. For those reasons, the carrier's extent denial is unsupported. The services in dispute are eligible for payment.

3. 28 Texas Administrative Code §134.204 (h) (2) (A) (B) states in pertinent part,

   > (2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.
   >
   > (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 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 eight minutes and less than 23 minutes.

The charges in dispute for date of service September 11, 2017 are as follows:

- 97545 -WC, CA, 1 unit for $72.00
- 97546 -WC, CA, 2 units for $72.00

The charges in dispute for date of service September 20, 2017 are as follows:

- 97545 -WC, CA, 1 unit for $72.00
- 97546 -WC, CA, 1 unit for $36.00

The total allowable reimbursement for the services in dispute is $252.00. This amount 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 $252.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $252.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	December , 2018
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 Rule §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 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. **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.