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
Genco

Respondent Name
Security National Insurance Co

MFDR Tracking Number
M4-19-3420-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services were pre-authorized, provided and submitted (received by insurance) timely and should be paid."

Amount in Dispute: $680.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, no additional reimbursement is owed because Requestor was correctly paid in accordance DWC Rule 134.230."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2018	97545 WH, 97545 WH -59	$680.00	$0.00

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 reimbursement guidelines for workers compensation 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
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

Is the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier reduced the services as "non-accredited interdisciplinary program." 28 TAC §134.204 (h) (1) and (3) states in pertinent part,

> (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.
> >
> > (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.
>
> (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.

Review of the medical bill found the submission of Code 97545 -WH, for 1 unit and Code 97546 -WH for 6 units. The MAR per requirements of the above stated Rule is $64.00 – 20% = $51.20 x 2 units - $102.40. $51.20 x 6 = $307.20. The total allowed amount is $409.60. The carrier paid $409.60. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 12, 2019 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.