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
OCCUFIT

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-3592-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We ask that you please reconsider our bill and process it correctly with the correct reimbursement amount."

Amount in Dispute: $256.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider was entitled to total reimbursement of $1,792.00, which the carrier has paid. See the carrier's EOB dated December 26, 2018. The provider is not entitled to any additional reimbursement."

Position Summary Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2018 thru December 13, 2018	CPT Codes 97545-WH and 97546-WH (40 Hours) Work Hardening	$256.00	$256.00

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

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.230, effective July 7, 2016 sets out the reimbursement guidelines for rehabilitation management programs.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor due additional reimbursement for work hardening program rendered from December 4, 2018 thru December 13, 2018?

Finding

1. The respondent paid for the work hardening program rendered from December 4, 2018 thru December 13, 2018 based upon "P12-Workers' compensation jurisdictional fee schedule adjustment."
2. A review of the submitted billing indicates the requestor billed for eight (8) hours of work hardening per day using CPT codes CPT codes 97545-WH and 97546-WH. The submitted documentation supports billed service; therefore, reimbursement per 28 Texas Administrative Code §134.230(3) is recommended.
3. Per 28 Texas Administrative Code §134.230 the appropriate reimbursement for the work hardening program, CPT codes 97545-WH and 97546-WH is:

    - 28 Texas Administrative Code §134.230(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 maximum allowable reimbursement (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."

    - 28 Texas Administrative Code §134.230(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 eight minutes and less than 23 minutes."

DATE	CODE	No. of Hours	MAR	IC PAID	AMOUNT DUE
December 4, 2018 thru December 13, 2018	97545-WH & 97546-WH	40	$64.00 X 80% = $51.20/hr X 40 hours = $2,048.00	$1,792.00	$256.00

Conclusion

For the reasons stated above, the Division finds that the requestor hast established that additional reimbursement is due. As a result, the amount ordered is $256.00.

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 $256.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/25/2019 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 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