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
ACTION PHYSICAL THERAPY

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-4973-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JULY 23, 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: $2,016.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ACTION THERAPY CENTERS submitted a bill for cpt codes 97545 and 97546, documentation supports total time 180 minutes (3hours), however treatment is not consistent with time documented and billed….At the time of audit, there was insufficient evidence to support the treatment codes billed, therefore denial code 225 was noted on the bill as documentation does not support the service being billed."

Position Summary Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 8, 2019 thru April 18, 2019	CPT Codes 97545-WC and 97546-WC (3 Hours per day, X 7 days for a total of 27 Hours) Work Conditioning	$2,016.00	$588.00

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 medical fee disputes.
2. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
3. The services in dispute were reduced or denied payment based upon reason code(s):
    - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
    - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891-No additional payment after reconsideration.
- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code and descriptions/instructions.

Issues

Is the requestor entitled to reimbursement for work conditioning program rendered from April 8, 2019 thru April 18, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution for reimbursement of $2,016.00 for work conditioning program rendered from April 8, 2019 thru April 18, 2019.

2. The respondent denied reimbursement for the work conditioning program based upon "CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," and "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information."

3. The fee guideline for work conditioning program is found in 28 Texas Administrative Code §134.230.

4. A review of the submitted billing indicates the requestor billed for three (3) hours of work conditioning per day for seven days using CPT codes CPT codes 97545-WC and 97546-WC. The submitted medical reports support billed service; therefore, reimbursement is recommended.

5. To determine the appropriate reimbursement for the work conditioning program, the division refers to the following statute:

   - 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(2) states, "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."

6. The division reviewed the submitted billing and finds the requestor billed for a non CARF accredited work conditioning program. The following table reflects the division's findings:

CODE	No. of Hours	MAR	IC PAID	AMOUNT DUE
97545-WC & 97546-WC	3 Hours per day X 7 days = 21 Hours	$36.00 X 80% = $28.00/hr X 21 hours = $588.00	$0.00	$588.00

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 $588.00.

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 $588.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		08/22/2019
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