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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ERGONOMIC REHAB OF HOUSTON

MFDR Tracking Number
M4-20-1032-01

MFDR Date Received
DECEMBER 23, 2019

Respondent Name
NORGUARD INSURANCE CO

Carrier's Austin Representative
Box Number 06

REQUESTOR'S POSITION SUMMARY

"The DWC rules state that the first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97546 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 allowable amount for work hardening per the TDI/DWC is $64.00 per hour/unit."

Amount in Dispute: $2,544.00

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2019 through July 15, 2019	Work Hardening Program CPT Code 97546-WH-CA (53 Hours)	$2,544.00	$2,544.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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):
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 350-Bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is the requestor entitled to additional reimbursement for work hardening program rendered from July 1, 2019 through July 15, 2019?

Findings

1. The Austin carrier representative for Norguard Insurance Co is Stone Loughlin & Swanson LLP. Stone Loughlin & Swanson LLP acknowledged receipt of the copy of this medical fee dispute on December 31, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
2. The requestor is seeking medical fee dispute resolution for reimbursement of $2,544.00 for work hardening program rendered from July 1, 2019 through July 15, 2019.
3. The respondent reimbursed the requestor $848.00 for the work hardening program based upon the fee guideline.
4. The fee guideline for work hardening program is found in 28 TAC §134.230.
5. To determine the appropriate reimbursement for the work hardening program, the DWC refers to the following statute:
   - 28 TAC §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 TAC §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."
6. The DWC reviewed the submitted billing and finds the requestor billed for a CARF accredited work hardening program. The following table reflects the DWC's findings:

CODE	No. of Hours	MAR	IC PAID	AMOUNT DUE
97546-WH-CA	53	$64 X 53 hours = $3,392.00	$848.00	$2,544.00

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,544.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $2,544.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	______________________	02/13/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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