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**
PAIN AND RECOVERY CLINIC

**Respondent Name**
ACCIDENT FUND INSURANCE CO OF AMERICA

**MFDR Tracking Number**
M4-21-0141-01

**Carrier's Austin Representative**
Box Number 06

**MFDR Date Received**
SEPTEMBER 29, 2020

## *REQUESTOR'S POSITION SUMMARY*

"We obtained preauthorization and billed according to division rules and regulations. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

**Disputed Amount:** $160.00.00

## *RESPONDENT'S POSITION SUMMARY*

"Based on this review, Accident Fund's position is that the bill was appropriately reduced."

Response Submitted By: Stone Loughlin & Swanson, LLC

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 29, 2020 | Work Hardening Program<br>CPT Code 97546-WH-CA<br>(4.5 Hours) | $160.00 | $160.00 |

## *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.
   - 97-Payment adjusted because the benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 3244-The billing of the procedure code has exceeded the National Correct Coding Initiative/Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. An

allowance has not been paid.

- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

**Issues**

Is the requestor entitled to additional reimbursement for work hardening program rendered on July 29, 2020?

**Findings**

1. The requestor is seeking medical fee dispute resolution for reimbursement of $160.00 for work hardening program rendered on July 29, 2020.

2. The respondent reduced payment for the disputed services based upon reason code 3244 (description listed above).

   On July 27, 2020, the requestor obtained preauthorization for an 80 hour work hardening program.

   The DWC finds the reports also refer to a Medicare payment policy regarding Medically Unlikely Edit (MUE). MUE's were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

   Although the DWC adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

   The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reason is not supported.

3. The fee guideline for work hardening program is found in 28 TAC §134.230.

4. 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 | 4.5 | $64.00 X 4.5 hours = $288.00 | $128.00 | $160.00 |

**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 $160.00.

## *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 $160.00, 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 | 11/02/2020<br>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**