



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

PAIN AND RECOVERY CLINIC

Respondent Name

TRUCK INSURANCE EXCHANGE

MFDR Tracking Number

M4-21-0172-01

Carrier's Austin Representative

Box Number 14

MFDR Date Received

OCTOBER 2, 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: \$252.00

RESPONDENT'S POSITION SUMMARY

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

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include May 1, 2020; May 8, 2020; and TOTAL.

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.
- 95-Plan procedures not followed.
- U03-The billed service was reviewed by UR and authorized.

- 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 entitled to additional reimbursement for work conditioning program rendered on May 1 and 8, 2020?

Findings

1. The Austin carrier representative for Truck Insurance Exchange is Courtney James Triggs. Courtney James Triggs received a notification of this medical fee dispute on October 5, 2020. 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 \$252.00 for work hardening program rendered on May 1 and 8, 2020.
3. The respondent paid \$18.00 per day for CPT code 97546-WC-CA based upon the fee guideline.
4. The fee guideline for work conditioning 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(2) states, “(2) 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 DWC reviewed the submitted billing and finds the requestor billed for a CARF accredited work conditioning program. The following table reflects the DWC’s findings:

CODE	No. of Hours per day	MAR	IC PAID	AMOUNT DUE
97546-WH-CA	2	\$36.00 X 2 hours = \$72.00	\$18.00	\$54.00 per day X 2 days = \$108.00

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 \$108.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$108.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	12/14/2020
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