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
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-0424-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 12, 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: $192.00

RESPONDENT'S POSITION SUMMARY

"It is the carrier's position that the provider is not entitled to any additional reimbursement."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2020	Work Hardening Program CPT Code 97546-WH-CA (4 Hours)	$192.00	$0.00

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.
    - 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 hardening program rendered on September 1, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution for reimbursement of $192.00 for work hardening program rendered on September 1, 2020.

2. The respondent originally paid $64.00 for the disputed services based upon the fee guideline. Upon receipt of this dispute, the respondent issued an additional payment of $192.00 on September 18, 2020.

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	$64.00 X 4 hours = $256.00	$256.00	$0.00

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/3/2020 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