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
ELITE HEALTHCARE NORTH DALLAS

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-0945-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 9, 2021

REQUESTOR'S POSITION SUMMARY

"The attached dates of service were not paid in full."

Disputed Amount: $12.80

RESPONDENT'S POSITION SUMMARY

"He indicated that he was reimbursed $38.40 for the second unit. He is seeking additional reimbursement of $12.80. WE are attaching a copy of the provider's CMS-1500s and the carrier's EOBs dated September 7, 2020 and December 28, 2020. Those EOBs support the carrier's position."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2020	Work Hardening Program CPT Code 97546-WH	$12.80	$12.80

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 July 30, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution for reimbursement of $12.80 for work hardening program rendered on July 30, 2020.

2. The respondent contends that payment was per the fee guideline; therefore, additional reimbursement is not due.

3. The requestor noted on the DWC-60 that payment of $38.40 had been received for the disputed work hardening program billed with CPT code 97546-WH.

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 non-CARF accredited work hardening program. The following table reflects the DWC's findings:

CODE	No. of Hours	MAR	IC PAID	AMOUNT DUE
97546-WH	1	$64.00 X 80% = $51.20	$38.40	$12.80

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 $12.80.

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 $12.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		3/11/2021
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