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
OCCUFIT-ROBERT ZUNIGA, DC

Respondent Name
MCALLEN ISD

MFDR Tracking Number
M4-21-1446-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
APRIL 16, 2021

REQUESTOR'S POSITION SUMMARY

"Our office is trying to collect on the dates of services listed, services were provided, services were approved/pre-authorized."

Disputed Amount: $2,048.00

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
May 12, 2020 May 13, 2020 May 14, 2020 May 15, 2020 May 19, 2020	Work Hardening Program CPT Code 97545-WH	$102.40/per date	$512.00
	Work Hardening Program CPT Code 97546-WH (X6) (A total of 30 Hours billed on these dates)	$307.20/per date	$1,536.00
TOTAL		$2,048.00	$2,048.00

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 February 22, 2021 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.
   - P12-Workers' compensation medical treatment guideline adjustment.
   - 151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

- 151-Based on the code's description, guidelines, anatomical considerations or the nature of service, the maximum number of units of this procedure code has been exceeded for this date of service.
- P12-A procedure has been billed which is out of the scope of practice for this provider.
- P12-The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.
- T113-Level 1 appeal means a request for reconsideration under 133.250.
- 16-Claim/service lacks information or has submission/billing error(s).
- B13-Previously paid. Payment for this service may have been provided ina previous payment.

Issues

Is the requestor entitled to additional reimbursement for work hardening program rendered from May 12, through May 19, 2020?

Findings

1. The Austin carrier representative for McAllen ISD is Dean G Pappas Law Firm LLC. Dean G Pappas Law Firm LLC received a copy of this medical fee dispute on April 20, 2021. 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 $2,048.00 for work hardening program rendered from May 12, through May 19, 2020.

3. The respondent denied payment for the disputed work hardening program based upon "P12-A procedure has been billed which is out of the scope of practice for this provider." The DWC finds the respondent did not submit any documentation to support this denial; therefore, the respondent's denial based upon not in provider's scope of practice is not supported.

4. The respondent also denied payment for the disputed work hardening program based upon "151-Based on the code's description, guidelines, anatomical considerations or the nature of service, the maximum number of units of this procedure code has been exceeded for this date of service," and " 151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."

   The requestor contends that reimbursement is due because the services were preauthorized. In support of their position, the requestor submitted a copy of a preauthorization report from Tristar dated May 11, 2020 preauthorizing 10 eight hour sessions for a total of 80 hours. The requestor did not exceed the eight hour session per date.

   The DWC finds the respondent's denial based upon reason code "151" is not supported.

5. The respondent also denied payment for the disputed work hardening program based upon "16-Claim/service lacks information or has submission/billing error(s)."

   The DWC finds the requestor submitted work hardening reports that support billed services; therefore, the respondent's denial based upon reason code "16" is not supported

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

7. 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	No. of Dates X MAR	IC PAID	AMOUNT DUE
97545-WH	2	$64.00 X 80% = $51.20 X 2 hours = $102.40	$102.40 X 5 = $512.00	$0.00	$512.00
97546-WH	6	$64.00 X 80% = $51.20 X 6 hours = $307.20	$307.20 X 5 = $1,536.00	$0.00	$1,536.00

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $2,048.00.

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 $2,048.00 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	6/16/2021 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