TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
PEAK INTEGRATED HEALTHCARE

Respondent Name
ZURICH AMERICAN INSURANCE CO.

MFDR Tracking Number
M4-22-2603-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 10, 2022	Work Hardening Program 97546-WH x 1	$51.20	$51.20
	Total	$51.20	$51.20

Requestor's Position

"This date of service was denied payment for "WORKERS COMPENSATION JURSIDICTIONAL FEE ADJUSTMENT. "Please see the corrected billing to reflect the correction of the WH units, and resubmit for adjudication. After this reconsideration it was denied again for the same reasons."

Amount in Dispute: $51.20

Respondent's Position

"our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230 sets out the reimbursement guidelines for return-to-work rehabilitation programs.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 90583 & 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract.

Issues

1. What is the date of service in dispute?
2. Is the requestor entitled to reimbursement of CPT 97546-WH rendered March 10, 2022?

Findings

1. The requestor indicates that date of service March 14, 2022 is disputed on the "Table of Disputed Services," however the requestor refers to date of service March 10, 2022 on the position statement, the EOBs and CMS-1500s. The DWC will therefore review date of service, March 10, 2022, as supporting documentation was submitted for this date.
2. The requestor is seeking medical fee dispute resolution for additional reimbursement of $51.50 for one unit of work hardening rendered from March 10, 2022.

   The respondent denied payment for the disputed work hardening based upon the denial reasons indicated above. The DWC finds that the requestor billed and documented 2 units of additional work hardening services, billed with CPT Code 97546-WH.

   The respondent did not submit documentation to support the denial reasons indicated above. The DWC finds the respondent's denial reasons are not supported. As a result, the requestor is entitled to additional reimbursement for one unit of CPT Code 97546-WH.

The fee guideline for work hardening program is found in 28 TAC §134.230. To determine the appropriate reimbursement for the work hardening program, the DWC refers to the following:

- 28 TAC §134.230(1)(B) states "Accreditation by the CARF is recommended, but not required.

  (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."

Date of Service	CPT Code	# Units	MAR $51.20 per unit	IC paid	Amount Due
3/10/22	97546-WH	2	$51.20	$51.20	$51.20
TOTAL		2	$51.20	$51.20	$51.20

The DWC finds that the requestor is therefore entitled to additional reimbursement in the amount of $51.20.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $51.20 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $51.20 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 01, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.