



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PRC HEALTH SERVICES, LLC

Respondent Name

TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number

M4-23-0149-01

Carrier's Austin Representative

Box Number 5

DWC Date Received

September 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 1, 2022 and June 2, 2022	97546-WH	\$204.80	\$204.80
Total		\$204.80	\$204.80

Requestor's Position

"After requesting reconsideration in a timely fashion VIA mail to Travelers, it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized. We obtained preauthorization and billed according to division rules and regulations. We feel that our facility should be paid according to the correct workers compensation fee schedule guidelines."

Amount in Dispute: \$204.80

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for the disputed service. The Carrier has reviewed the disputed billing and confirmed the Provider was reimbursed according to the Medicare edits for the maximum billed units of two per day. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response Submitted by: Travelers

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 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:

- P12-WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 97-PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 309-THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- 3244-THE BILLI INITIATIVE MEDICALLY UNLIKELY EDITS AMOUNT FOR THE NUMBER OF TIMES THIS PROCEDURE CAN BE BILLED ON A DATE OF SERVICE. AN ALLOWANCE HAS NOT BEEN PAID.
- 947-UPHELD NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.

Issues

1. Is the requestor entitled to additional reimbursement for work hardening program rendered on June 1, 2022 and June 2, 2022?
2. What rules apply to the reimbursement of a work hardening program?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks an additional payment in the amount of \$204.80 for work hardening services billed under CPT 97546-WH x 4 units and rendered on June 1, 2022 and June 2, 2022. The insurance carrier issued a payment in the amount of \$204.80.

The respondent denied payment with denial reason code "P12." The DWC finds the respondent did not submit documentation to support this denial reasons; therefore, the respondent's denial based upon P12 is not supported.

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 the billing of work hardening services; therefore, the respondent's denial based upon reason code "16" is not supported

2. 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 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 MA.
- 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."

3. 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:

DOS	CPT Code	# units	MAR \$51.20/unit	IC Paid	Amount Sought	Amount Due
6/1/2022	97546-WH	4	\$204.80	\$102.40 (2 units)	\$102.40	\$102.40
6/2/2022	97546-WH	4	\$204.80	\$102.40 (2 units)	\$102.40	\$102.40
Total		8	\$409.60	\$204.80	\$204.80	\$204.80

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 \$204.80 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 \$204.80 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 8, 2022
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 electrónico CompConnection@tdi.texas.gov.