



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

PEAK INTEGRATED HEALTHCARE

Respondent Name

WESCO INSURANCE COMPANY

MFDR Tracking Number

M4-23-0265-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

September 29, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2022 through March 30, 2022	97546-WH	\$1,305.60	\$51.20
Total		\$1,305.60	\$51.20

Requestor's Position

"I have attached the authorization for these dates of service. These services billed re PRE-AUTHORIZED work hardening visits. Per RULE 136.600 [134.600], the carrier shall not withdraw ore-authorized once issued. I have also attached AM Trust/Mitchell Worker Hardening Approval REF #5285672 that was determined to be medically necessary and within guidelines for the compensable injury. I have also attached a 3/16/2022 date of service that was correctly paid in full. Therefore, these bills and units billed should be paid in full."

Amount in Dispute: \$1,305.60

Respondent's Position

"The Carrier is currently issuing payments on the medical bills in dispute pursuant to the attached EOBs. Carrier requests that the Provider withdraw this dispute once the payments have been received. The Carrier further requests that Medical Fee Dispute Resolution assist with the procurement of a withdrawal from the Provider or issue a Findings and Decision stating no additional monies are owed."

Response Submitted by: Downs Stanford, P.C.

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:

- 320-NON-ACCREDITED INTERDISCIPLINARY PROGRAM. PAYMENT REDUCED 20% BELOW MAR OR 20% BELOW USUAL AND CUSTOMARY.
- 350-BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 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

1. Did the insurance carrier submit sufficient documentation to support that payments were issued for the disputed services?
2. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for work hardening services rendered on February 21, 2022 through March 30, 2022. The requestor indicates that the insurance carrier issued payments for all disputed dates of service, with the exception of date of service, March 30, 2022.

The requestor seeks an additional payment of \$76.80 for CPT code 99546-WH x 2 units rendered on March 30, 2022. Review of the submitted documentation, supports that the insurance carrier issued a payment in the amount of \$25.60 on September 2022 and issued a supplemental payment in the amount of \$25.60 in November 2022. The DWC finds that the remaining disputed amount therefore, \$51.20.

2. The fee guideline for work hardening programs 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 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."

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 BILLED	BILLED AMT	MAR \$51.20/UNIT	IC PAID AMT	AMT IN DISPUTE	AMT ORDERED
3/30/2022	97546-WH	2	\$102.40	\$51.20 X 2 = \$102.40	\$51.20	\$76.80	\$51.20
TOTALS		2	\$102.40	\$102.40	\$51.20	\$76.80	\$51.20

The DWC finds that the requestor is therefore entitled to an additional payment for one (1) unit of CPT 97546-WH. As a result, \$51.20 is recommended.

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 additional 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

_____	_____	March 14, 2023
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 electrónico CompConnection@tdi.texas.gov.