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
GREAT AMERICAN ALLIANCE INSURANCE CO.

MFDR Tracking Number
M4-23-1159-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 19, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 28, 2022	99080-73, and 99214	$251.35	$0.00
January 31, 2022	97546-WH	$38.40	$38.40
	Total	$289.75	$38.40

Requestor's Position

"The above dates of service were denied full payment stating, 'WORKERS COMPENSATION JURISDICTIONAL FEE ADJUSTMENT.' This is incorrect. Office visits are recommended as determined to be medically necessary. Furthermore, I have attached a previous payment 03/09/2022 for the same 'preauthed' work hardening services that were paid correctly 'in full.' Please reprocess for FULL payment to avoid MFDR."

Amount in Dispute: $289.75

Respondent's Position

"The provider continued to actively treat and focus treatment on non-related body parts that were disputed on PLN-11 filings in January 2021 and May 2021 (both included) and as such the carrier disputed the office visit as being not related to the compensable injury. Also included in this exchange is some prior visits with the same doctor and a referral to a specialist with focus on the non-related [injury]."

Response Submitted by: Great American Insurance Group.

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. Texas Labor Code, Chapter 413 sets out the rights and responsibilities related to medical dispute resolution.
2. 28 Texas Administrative Code (TAC) §133.240 sets out the requirements for submission of a medical bill
3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 TAC §133.305 sets out the procedures for resolving medical disputes.
5. 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:

- B81 – Denied/controverted claim or date of service is after the date of denial.
- P4 – Workers' compensation claim adjudicated as non-compensable this payer not liable for claim or service/treatment.
- B49, B81 – Denied claim-treatment for non-related body parts.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 375 – No allowance is recommended for dos 1/31/22 only.
- 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
- W3– In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- U03 – The billed service was reviewed by UR and authorized.
- 229 – Procedure does not appear related to the injury and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.
- P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies.
- P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.

Issues

1. Has the insurance carrier issued payment for the work hardening service in accordance with 28 TAC §134.230?
2. Is the Requestor eligible for DWC medical fee dispute resolution for the services in question?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97546-WH x 1 unit, rendered on January 31, 2022. The insurance carrier issued a payment in the amount of $12.80 and denied the remaining charge with denial reason code "P12, 375, 320, W3, 350, and U03", descriptions provided above.

   The insurance carrier's position summary states, "Carrier paid the 1/31/2022 date of service per fee schedule, see following EOB and cleared check."

   Review of the medical bill finds that the requestor billed for one unit of CPT Code 97546-WH and did not append modifier "CA" to billed code. To determine the appropriate fee guideline for the work hardening service, the DWC refers to 28 TAC §134.230.

   - 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 requestor seeks an additional payment of $38.40. The insurance carrier issued a payment of $12.80. The reimbursement for CPT code 97546 is $64.00 for each additional hour x 80% for a non-CARF accredited program, which equals a MAR amount of $51.20. The requester is therefore entitled to an additional payment amount of $38.40. This amount is recommended.

2. The requestor seeks reimbursement for CPT Code 99214 and 99080-73 rendered on January 28, 2022. The insurance carrier states in pertinent part, "Carrier agrees this is the proper venue for the 1/31/22 date of service as to whether it was paid per TX fee schedule, however, disagrees to this being the proper venue for the 1/28/22 date of service as that was denied as not related to the compensable injury and is not a dispute over proper application of the fee schedule."

The insurance carrier denied the disputed services with denial reduction code:

- P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal
- 229 – Procedure does not appear related to the injury and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.

The DWC finds that if a dispute over the compensability, extent of injury, or liability exists for the same service(s) for which there is a medical fee dispute.

28 TAC §133.305 (b) states that the compensability, extent of injury/relatedness, liability dispute must be resolved before submission of a medical fee dispute resolution request for the service(s).

The insurance carrier denied payment due to an unresolved compensability, extent of injury/relatedness, liability issue. The insurance carrier notified the requestor of the denial on an explanation of benefits as defined by 28 TAC §133.240.

The insurance carrier also presented a copy of a Plain Language Notice for the issue to DWC, as required by 28 TAC §133.307 (d)(2)(H). No evidence was submitted to indicate that the issue was resolved before submitting this request for medical fee dispute resolution.

The DWC concludes that an unresolved compensability, extent of injury/relatedness, liability issue exists for the service(s) in dispute.

The DWC finds that good cause exists to dismiss CPT Codes 99214 and 99080-73 rendered on January 28, 2922, in accordance with 28 TAC §133.307 (f)(3).

3. The DWC finds that the requestor has established that additional reimbursement in the amount of $38.40 is due, for CPT code 97546-WH rendered on January 31, 2022. Therefore, this amount 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 reimbursement of $38.40 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 $38.40 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	April 24, 2023 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 managing 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.