Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Main Rehab and Diagnostic 3523 McKinney Avenue Ste 246 Dallas, Texas 75204-1401	MFDR Tracking #: M4-05-0128-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Company Rep Box # 54	Date of Injury: Employer Name: Texas Galvanizing Inc Insurance Carrier #: 99D0000359460

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…On dates of service 2/11/4 and 2/16/4, the work hardening was denied as not preauthorized."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary states in part …" It is this carrier's position that the requester did not obtain preauthorization for the dates of service in dispute; therefore, no reimbursement is due."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01-28-04	G/O	99080-QU	1 - 3	$00.00
02-11-04 & 02-16-04	A/O	97545-WH-CA-QU (1 unit @ $128.00 x 2 DOS)	1, 3-5	$256.00
02-11-04 & 02-16-04	A/O	97546-WH-CA-QU (1 hour @ $64.00 x 3 hours x 2 DOS)	1, 3-5	$384.00
Total Due:				$640.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

On June 27, 2007 the Requestor withdrew CPT code 99213 listed on the Table of Disputed Services for dates of service 10-29-03 through 12-18-03. These services will not be a part of the review.

1. These services were denied by the Respondent with reason codes:
   - G - Reimbursement for this procedure is included in the basic allowance for another procedure.
   - A - Preauthorization required but not requested.
   - O - Denial after reconsideration.

2. Per Rule 134.202(b) CPT code 99080 is not global to other services billed on date of service 01-28-04. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation for review. Per review of the CMS-1500 submitted by the Requestor it could not be determined what service the Requestor was billing for; therefore, no reimbursement is recommended.

3. Per review of Box 32 on CMS-1500 zip code 76106 is located in Tarrant County.

4. Regarding CPT codes 97545-WH-CA and 97546-WH-CA Rule 134.600(h)(9) effective 03-14-04 states in part "work hardening and/or work conditioning programs initiated on or after January 1, 2004 and prior to March 15, 2004, are subject to preauthorization and concurrent review…" The Requestor obtained preauthorization on 01-13-04 (preauthorization number GAG01094PR) authorizing work hardening for four weeks. The Respondent has denied the service inappropriately and is in violation of Rule 134.600(h)(9).

5. Reimbursement is recommended per Rule 134.202(e)(5)(A)(i) and Rule 134.202(e)(5)(C)(i) and (ii) in the following amounts:

   CPT code 97545-WH-CA-QU - $256.00 (1 unit @ $128.00 x 2 DOS)
   CPT code 97546-WH-CA-QU - $384.00 (1 hour @ $64.00 x 3 hours = $192.00 x 2 DOS)

A Legal and Compliance referral is made due to the Respondent denying with a improper denial and in violation of Rule 134.600.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.600, §133.307 and §134.202

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $640.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

07-13-07

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.