Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Ergonomic Rehabilitation of Houston 283 Lockhaven, Suite 315 Houston, TX 77073	MFDR Tracking #: M4-05-2738-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Southwestern Bell Telephone LP Rep. Box # 17	Date of Injury: Employer Name: Southwestern Bell Telephone LP Insurance Carrier #: 949742032

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…It is the contention of Ergorehab that it, as a CARF accredited facility, was exempt from the preauthorization requirements because Mr. Garcia's Work Hardening program was initiated prior to January 1, 2004. The Work Hardening program was initiated on December 18, 2003 with Mr. Garcia's Functional Capacity Evaluation…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Charges were denied because preauthorization was not requested…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
01/05/04-2/05/04	X170	97545-WH-CA	1-2	00.00
01/05/04-2/05/04	X170	97546-WH-CA	1-2	00.00
Total Due:				00.00

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.

1. This dispute relates to procedures 97545-WH-CA (Initial 2 hours) and 97546-WH-CA (Each additional Hour) and Respondent's denial of payment based upon, Initial denial – X170 – "Pre-authorization was required, but not requested for this service per TWCC Rule 134.600." The reconsideration denial was the same.

2. According to Rule 134.600(h)(9), preauthorization was required for Work Hardening from 1/01/04-3/15/04; therefore, no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION DECISION AND/OR 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 not entitled to reimbursement.

Decision:

	Scott Hansen	04/10/07
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.