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: Unique Medical & Rehab Center 6400 Westpark, Suite 480 Houston, Texas 77057	MFDR Tracking #: M4-05-9996-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: BENCHMARK INSURANCE COMPANY REP BOX #: 17	Date of Injury: Employer Name: Richfield Investment Corp. Insurance Carrier #: 169529

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Pre-approved."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Approval Letter dated 04/08/05, preauthorization approval #5250-83102

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The provider received a preauthorization for 10 sessions only of Work Hardening; the provider was PAID for services originally billed, based on the units billed for 97546 WH, for the 10 days precertified; the provider submitted a CORRECTED bill, marked 'request for reconsideration', which is an invalid request for reconsideration, as the original bill was changed/altered; upon review of the submitted records for date 04/08-/0421/2005, the carrier denied the additional units of 97546-WH, as the records did not support the CPT code billed; the records did not show a highly-specific program, tailored to the injured worker's return to work needs and criteria; the provider is NOT a CARF accredited facility, and would not be paid the full billed amount, but at a reduced rate, as set for in the Medical Fee Guidelines. The carrier has paid for 10 dates of WH, but has not provided for the additional units, as the program does not meet the criteria of a Work Hardening Program, based on the medical records provided. The Provider submitted an INVALID request for reconsideration. The Carrier contends that all services were paid correctly and in accordance with the fee guidelines, based on the materials provided..."

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
04/08/05-04/22/05	W1, YF/W1, YO	97545-WH x 1 Unit x 11 Days 97546-WH x 6 Hours x 11 Days	1 2 & 3	$00.00 $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.

Preauthorization approval #5250-83102 was given on 04/08/05 for a Work Hardening Program, ten (10) sessions with a start date of 04/08/05 and an end date of 05/08/05.

Rule 134.600(c)(i)(B), states, "…The carrier is liable for all reasonable and necessary medical costs relating to the health care…listed in subsection (p) or (q) of this section only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care…" Per Rule 134.202(e)(5)(A)(ii), A Non-CARF accredited program shall be reimbursed at 80% of the MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00 per hour."

Rule 134.304(k)(1)(B), states, "If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit the request for reconsideration by facsimile or mutually agreed upon electronic transmission unless the request cannot be sent by those media, in which case the sender shall send the request by mail or personal delivery; the request shall include: a copy of the complete medical bill that the health care provider is requesting the insurance carrier to reconsider…with the identical codes and charges that are on the original medical bill…"

1. This dispute is related to CPT code 97545-WH x 1 unit for dates of service 04/08/05, 04/11/05, 04/12/05, 04/13/05, 04/14/05, 04/15/05, 04/18/05, 04/19/05, 04/20/05, 04/21/05 and 04/22/05 that were denied with reason codes "W1/YF—RC YF Fee Guidelines MAR Reduction" and "W1/YO—RC YO Denial After Reconsideration." The Requestor's CMS-1500 was not billed with a modifier to indicate they are a CARF accredited facility. The Respondent has correctly reimbursed for the dates of service, therefore, no additional reimbursement is recommended.

2. This dispute is related to CPT code 97546 WH x 6 hours for dates of service 04/08/05, 04/11/05, 04/12/05, 04/13/05, 04/14/05, 04/15/05, 04/18/05, 04/19/05, 04/20/05, 04/21/05 and 04/22/05 that were denied with reason codes "W1/YF—RC YF Fee Guidelines MAR Reduction" and "W1/YO—RC YO Denial After Reconsideration." The Requestor's CMS-1500 was not billed with a modifier to indicate they are a CARF accredited facility. The Respondent has correctly reimbursed for the dates of service, therefore, no additional reimbursement is recommended.

3. In review of the Requestor's submitted documentation, the original CMS-1500 indicates that CPT code 97546-WH was billed for 1 hour on each of the disputed dates of service. However, the CMS-1500 submitted for reconsideration indicates that were was a correction made and CPT code 97546-WH was billed for 6 hours on each of the disputed dates of service. The Requestor submitted a corrected bill marked "request for reconsideration", which is an invalid request for reconsideration, as the original bill was changed/altered. Per Rule 134.304(k)(1)(B), the Requestor's request for reconsideration did not reflect the identical codes and charges that were billed on the original medical bill. The Requestor did not submit convincing evidence of carrier receipt for "Request for Reconsideration" in accordance with 133.307(g)(3)(A). The Requestor failed to submit the corrected bill to the Respondent for request for reconsideration and is therefore, not eligible for review by the Division.

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, §133.307, §134.304

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 by:

05/23/07

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.