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-A340-01 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 as taken from the Table of Disputed Services: "Pre-approved."
Principle Documentation:

1. DWC 60 package
2. CMS 1500
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: "A- only 10 session [sic]were preauthorized, provider billed 97545 & 97546 WH for dates 4/8, 4/11, 4/12, 4/13, 4/14, 4/15/, 4/18, 4/19, 4/20, and 4/21/05. The Provider has exceeded the number of visits preauthorized. No request for reconsideration submitted."

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
04/25/05-05/09/05	W1, YF/W1, RC YA W1, YF/W1, RC YA	97545-WH x 1 Unit x 11 Days 97546-WH x 6 Hours x 11 Days	1, 3 & 4 2, 3 & 4	$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.

1. This dispute is related to CPT code 97545-WH X 1 unit for dates of service 04/25/05, 04/26/05, 04/27/05, 04/28/05, 04/29/05, 05/02/05, 05/03/05, 05/04/05, 05/05/05, 05/06/05 and 05/09/05 that were denied with reason codes "W1/YF—RC YF Fee Guidelines MAR Reduction"; "W1/YA—RC YA Preauthorization required but not requested" and "W1/YO—RC YO Denial After Reconsideration."

2. This dispute is related to CPT code 97546 WH x 6 hours for dates of service 04/25/05, 04/26/05, 04/27/05, 04/28/05, 04/29/05, 05/02/05, 05/03/05, 05/04/05, 05/05/05, 05/06/05 and 05/09/05 that were denied with reason codes "W1/YF—RC YF Fee Guidelines MAR Reduction"; "W1/YA—RC YA Preauthorization required but not requested" and "W1/YO—RC YO Denial After Reconsideration."

3. Preauthorization approval #5250-83102 was given on 04/08/05 for a Work Hardening Program, x ten (10) sessions with a start date of 04/08/05 and an end date of 05/08/05. Eleven sessions of work hardening were performed from 4-8-05 through 04/22/05. The Requestor did not have preauthorization for an additional eleven sessions. Therefore, reimbursement is not 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, §133.307

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.