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

MEDICAL FEE DISPUTE RESOLUTION FINDING AND ORDER

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address: Forward Health Solutions P.O. Box 443 Burleson TX 76097	MDR Tracking No.: M4-05-A876-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TEXAS MUTUAL INSURANCE CO Rep Box #54	Date of Injury: Employer's Name: AUS MEX CO Insurance Carrier's No.: 99E0000373686

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

POSITION SUMMARY: Per the Requestor's letter of reconsideration to the Respondent "…we have not received an EOMB which gives us a denial code for these services. We have received Preauthorization from your UR department for these service and expect prompt reimbursement…"

Principle Documentation:

1. DWC-60
2. Letter requesting reconsideration
3. HCFA 1500's
4. Letters of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

POSITION SUMMARY: "…the requestor did not include the EOBs with the request for reconsideration…I have submitted the request for reconsideration the EOBs for processing…"

Principle Documentation:

1. DWC-60
2. Position Summary
3. EOBs

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
7/12/04 thru 7/23/004 and 8/2/04 thru 8/6/04	A	97545-WC-CA x 15 units (30 hrs) and 97546-WC-CA x 90 hrs	1	$4,104.00
7/28/04, 7/29/04 and 7/30/04	F	97545-WC-CA x 3 units (6 hrs) and 97546-WC-CA x 18 hrs	1	$172.80
TOTAL DUE				$4,276.80

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule §134.202 titled (Medical Fee Guideline For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, sets out reimbursement guidelines.

1. Codes 97545-WC-CA and 97546-WC-CA, for dates of service 7/12/04 thru 7/23/004 and 8/2/04 thru 8/6/04, were denied for "A – 03 – The procedure requires prior authorization." Per 28 Texas Administrative Code Sec. §134.600 (p), work conditioning is a procedure that requires preauthorization. Letters of preauthorization dated 7/8/04 and 7/23/04, were submitted by the Respondent and substantiates that preauthorization was obtained by the Requestor for 2 weeks of work conditioning between the dates of 7/12/04 and 8/13/04. Therefore, Per 28 Texas Administrative Code Sec. §134.600 (p) and 28 Texas Administrative Code Sec. §134.202 (d)(5)(A-B), reimbursement in the amount of $4,104.00 ($36.00 per hr x 120 hrs = $4,320.00 - $216.00 already paid = $4,104.00) is recommended.

2. Codes 97545-WC-CA and 97546-WC-CA, for dates of service 7/28/04, 7/29/004 and 7/30/04, payment was reduced with reduction code "F – 01 – The charge for the procedure exceeds the amount indicated in the fee schedule." Per 28 Texas Administrative Code Sec. §134.202 (d)(5)(A-B), "…The hourly reimbursement for a CARF accredited program shall be 100% of the MAR..." The MAR for work conditioning is $36.00 per hour. The Requestor is a CARF accredited facility and entitled to 100% of MAR. Therefore, reimbursement in the amount of $172.80 ($36.00 per hr x 24 hrs = $864.00 - $691.20 already paid = $172.80) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.202 (d)(5)(A-B)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.600 (p)

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 additional reimbursement in the amount of **$4,276.80** plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Order by:

	James Schneider	7/6/07
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.