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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

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

Requestor's Name and Address: Corpus Christi Pain Relief Center 3033 Fannin Houston, TX 77004	MDR Tracking No.: M4-07-0270-01 Claim No.: Injured Employee's Name:
Respondent's Name: Federal Insurance Co. Rep. Box # 17	Date of Injury: Employer's Name: West Flagler Assoc. LTD. Insurance Carrier's No.: 047505029022DELACR

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "No Response from carrier, after reconsideration. Services denied all were previously preauthorized."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits (EOBs)
4. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "The provider attached to their request for an MDR a preauth approval which does NOT correspond with the dates of service in dispute. The only preauth obtained by the provider was for work conditioning which was to be done between the dates 10/14/05 – 11/14/05; the dates of service in dispute are 9/17 – 9/20/05 which is prior to the approval the provider obtained through preauth."

Principle Documentation: 1. Response to DWC 60

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)
9-17-05 9-18-05 9-20-05	62	97545WC 97546WC	1-4	$00.00
TOTAL DUE				$00.00

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) effective August 1, 2003, sets out reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under CPT codes 97545WC and 97546WC that were denied/reduced reimbursement by the insurance carrier based upon: "62 – Pre-certification/authorization absent or exceeded."

2. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 9-11-06.

3. Based on Division Rule 133.307(d)(1-2), the only dates of service eligible for review are those commencing on 9-17-05 and extending through 9-20-05.

4. The Requestor obtained preauthorization approval for work conditioning for two weeks to be completed between 10/14/05 and 11/14/05. Per Rule 134.600(h)(9), work conditioning services require preauthorization. The Requestor did not submit any report to support preauthorization was obtained for the disputed dates; therefore, no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION DECISION

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:

	Elizabeth Pickle, RHIA	January 5, 2007
Authorized Signature	Typed Name	Date of Decision

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.