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: Advanced Total Rehabilitation 19009 Preston Road-Suite 215-106 Dallas, Tx 75252	MFDR Tracking #: M4-07-4527-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: HARTFORD UNDERWRITERS INSURANCE REP BOX #: 27	Date of Injury: Employer Name: Nuclear Logistics Inc Insurance Carrier #: YPU08064C

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "These Procedure Codes and Modifiers are valid as they are stated in Texas Codes, for treatment administered. This was the reason stated by the carrier for denial upon 1st bill submission, which we felt was invalid for the Carriers determination, we therefore, sent all documents back for Reconsideration, at which point, the claim was not reconsidered, it was sent out with note below, with no further actions being able to be taken or for a Medical Provider to gain remittance for these services."

Principle Documentation:

1. DWC 60 package
2. CMS 1500'S
3. EOB's
4. Pre- Authorization approval

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to this medical dispute.

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
09/14/06 –09/20/06	B18,193	97545-WH-GP	1,2	$00.00
09/14/06 –09/20/06	B18,193	97546-WH-GP	3, 4	$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. 1 The Requestor billed with CPT code 97545-WH for the dates of service 09/14/06-09/20/06. The Respondent used denial code, "B18 – Payment denied because this procedure code/modifier was invalid on the date of service or claim

submission. Procedure is not listed in the current state fee schedule" and after reconsideration the Respondent used denial code, "193 - Original payment decision is being maintained. Final action. In accordance with rule 133.250 (G): A health care provider shall not resubmit a request for reconsideration after the carrier has taken final action on the request."

2. The preauthorization approval was modified from a WH program to a WC program per rationale provided on PA# H4909189527. The partial approval stated that based on the review of provided records documentation did not support the request for work hardening x 20 sessions as reasonable and/or medically necessary. The requesting physician and the utilization review physician discussed having the employee participate in a work conditioning program, 4 hours per day, 5 x weeks for 2 weeks (10 sessions) which would be sufficient time to improve the employee's PDL and RTW. Per the CMS 1500, the Requestor billed for a work hardening program. Therefore, reimbursement is not recommended.

3. The Requestor billed with CPT code 97546-WH billed for the dates of service 09/14/06-09/20/06. The Respondent used denial code, "B18 – Payment denied because this procedure code/modifier was invalid on the date of service or claim submission. Procedure is not listed in the current state fee schedule" and after reconsideration the Respondent used denial code, "193 - Original payment decision is being maintained. Final action. In accordance with rule 133.250 (G): A health care provider shall not resubmit a request for reconsideration after the carrier has taken final action on the request."

4. The preauthorization approval was modified from a WH program to a WC program per rationale provided on PA# H4909189527. The partial approval stated that based on the review of provided records documentation did not support the request for work hardening x 20 sessions as reasonable and/or medically necessary. The requesting physician and the utilization review physician discussed having the employee participate in a work conditioning program, 4 hours per day, 5x weeks for 2 weeks (10 sessions) which would be sufficient time to improve the employee's PDL and RTW. Per the CMS 1500, the Requestor billed for a work hardening program. 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. §133.307 (effective 12/31/06)
28 Texas Administrative Code Sec. §134.1, §134.202

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:

04/30/07

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.