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: Chirotech Inc. – Matthew Jernigan, D.C. 4830 S. Freeway Fort Worth, TX 76115	MFDR Tracking #: M4-05-1251-01 DWC Claim #: Injured Employee:
Respondent Name: Zurich American Insurance Corp. Box #: 19	Date of Injury: Employer Name: Insurance Carrier #: 4650172740

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per Requestor's Table of Disputed Services, services were pre-authorized.

Principle Documentation:
1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…carrier denied a bill for $8,064.00 for work hardening because the provider was not the appropriate health care provider (K)." Per Respondents Table of Disputed Services: "IME on 08/14/03 indicates no further treatment reasonable or necessary."

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
10/13/03 – 11/04/03	K, 111-006, 910-054, 993-002	97545-WH	1, 2	$1,638.40
10/13/03 – 11/04/03	K, 111-006, 910-054, 993-002	97546-WH	3, 4	$4,812.80
Total Due:				$6,451.20

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. CPT code 97545-WH billed for dates of service 10/13/03 – 11/04/03 was denied by carrier denial codes "K" (Not Appropriate Health Care Provider), "111-006" (FHN contract status indicator duplicate service excluded) "910-054" (Hold all – audit only) and denial code "993-002" (Service denied. Provider not on the approved doctor list).

2. The Requestor submitted proof of certification on the ADL. Per Rule 180.23 (2), a Level 2 Certificate of Registration allows a doctor to serve in any role authorized in the Texas workers' compensation system with the exception of serving as a designated doctor. The Requestor provided proof of pre-authorization documentation for 20 sessions of Work Hardening and provided 16 sessions of Work Hardening under Pre-Auth#1204749. Per Rule 134.202(e) (5) (A) (ii) a Non-CARF

accredited program shall be reimbursed at 80% of the MAR. Per Rule 134.202(e)(5)(c), the first two hours of each session shall be billed and reimbursed as one unit. Reimbursement is recommended in the amount of $**1,638.40 ($64.00 X 80% = $51.20 per hour (MAR) X 2 hr. = $102.40 (1Unit) x 16 (Days).**

3. CPT code 97546-WH billed for dates of service 10/13/03 – 11/04/03 was denied by carrier denial codes "K" (Not Appropriate Health Care Provider), "111-006" (FHN contract status indicator duplicate service excluded) "910-054" (Hold all – audit only) and denial code "993-002" (Service denied. Provider not on the approved doctor list).

4. The Health Care Provider submitted proof of certification on the ADL. Per Rule 180.23 (2), a Level 2 Certificate of Registration allows a doctor to serve in any role authorized in the Texas workers' compensation system with the exception of serving as a designated doctor. The Requestor provided proof of pre-authorization documentation for 20 sessions of Work Hardening and provided 16 sessions of Work Hardening under Pre-Auth#1204749. Per Rule 134.202(e) (5) (A) (ii) a Non-CARF accredited program shall be reimbursed at 80% of the MAR. Reimbursement is recommended in the amount of **$4,812.80 ($64.00 X 80% = $51.20 per hour (MAR) X 94 hrs. (16 days).**

Respondent's Position Summary states, "IME on 08/14/03 indicates no further treatment reasonable or necessary." Pre authorization was obtained on 10/03/03 for 20 Work Hardening sessions. Per Rule 133.301(a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill fro treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$6,451.20** plus accrued interest, due within 30 days of receipt of this Order.

Findings & Decision:

Eileen V. Atkinson — **04/13/07**

Authorized Signature — Medical Fee Dispute Resolution Officer — Date

Order:

Marguerite Foster

Authorized Signature — Medical Fee Dispute Resolution Team Lead — 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.