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: Injury One Treatment Center 5445 La Sierra Dr. Ste 204 Dallas, Tx 75231-3444	MFDR Tracking #: M4-05-A270-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: American Home Assurance Co. REP BOX #: 19	Date of Injury: Employer Name: Alterra Healthcare Corp Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Gallagher Bassett has reduced payment for this patient's claims. The claimant was referred to our office by her treating physician. Injury One Treatment Center is a CARF accredited facility and reimbursement is made at 100%. Pre-auth was obtained for the ind psych sessions & the MAR was not paid. The treatments rendered were medically & reasonably necessary. I appreciate your help in resolving this matter."

Principle Documentation:

1. DWC 60 package/Updated Table
2. CMS 1500
3. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.001(d). The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately. As to certain dates of service, the billing was denied for lack of preauthorization. Insofar as preauthorization was required and was not obtained prior to provision of the service/treatment the provider has forfeited any right to reimbursement."

Principle Documentation:

1. Position Statement
2. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
01/20/05	No EOBs	97750 x 16 Units	1	$513.17
01/26/05 - 02/17/05	F, M, A	97545-WH-CA x 4 Units	2	$192.00
01/24/05 - 02/17/05	F, M, A	97546-WH-CA x 29 Hrs	3	$368.00
Total Due:				$1,073.17

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.

On 04/19/07the Requestor submitted an updated Table of Disputed Service which will be used for this review.

1. This dispute is related to CPT code 97750 x 16 units for date of service 01/20/05. Review of the Requestor and Respondent's documentation revealed that neither party submitted copies of EOBs however; review of the Requestor's documentation, reflected proof reconsideration was submitted on 02/11/05. Therefore, the disputed service will be reviewed according to the Medical Fee Guidelines. According to the Requestor's Updated Table of Disputed Services the Respondent initially paid $35.63. **($28.50 x 125% = $35.63 per unit (MAR) x 16 units = $570.08 – $35.63. = $534.45)**. Requestor had indicated on the Table of Disputed Services the amount in dispute to be $513.17. The maximum allowable reimbursement in accordance with Rule 134.202 (c) (1) is $570.08, however Requestor billed $548.80. Therefore, according to Rule 134.202(d)(2) additional reimbursement in the amount of **$513.17** is recommended.

2. This dispute is related to CPT code 97545-WH-CA x 4 units for dates of service 01/26/05 - 02/17/05 were denied initially with reason codes "M-Payment recommended at fair and reasonable rate.", "F-Recommend allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines." and "A-Service is denied for lack of proof preauthorization." An Updated Table of Disputed Services was submitted by the Requestor on 04/19/2007 for review. Per Rule 134.600(h), a CARF accredited program does not require pre-authorization of services. Requestor is a CARF accredited facility. In addition, per Rule 134.202(e) (5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00." Per Rule 134.202(e)(5)(c)(i), the first two hours of each session shall be billed and reimbursed as one unit. According to the Requestor's Updated Table of Disputed Services the Respondent initially paid $320.00. Additional reimbursement is recommended in the amount of **$192.00 ($64.00 per hour (MAR) x 2 hours (1unit) =$128.00 x 4 dos = $512.00 - $320.00=$192.00)**

3. This dispute is related to CPT code 97546-WH-CA x 29 hrs for dates of service 01/24/05 - 02/17/05, these dates of service were denied with reason codes "A-Service is denied for lack of preauthorization.", "F-Recommend allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines.", "A-Service is denied for lack of proof of pre-authorization.", "M-Payment recommended at fair and reasonable rate.", Per Rule 134.600(h), a CARF accredited program does not require pre-authorization of services. Requestor is a CARF accredited facility. In addition, per Rule 134.202(e) (5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00." According to the Requestor's Updated Table of Disputed Services the Respondent initially paid $1,488.00. Therefore, reimbursement is recommended in the amount of **$368.00 ($64.00 per hour (MAR) x 29 hours = $1,856.00 - $1,488.00=$368.00).**

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 entitled to additional reimbursement. The Division hereby ORDERS the Carrier to remit to the Requestor the amount of $1,073.17 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

06/18/07

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.