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

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

Requestor's Name and Address: Trinity Orthopedics, P.A. 809 W. Harwood Rd. Ste. 101 Hurst, Texas 76054	MDR Tracking No.: M4-07-0231-01 Claim No.: Injured Employee's Name:
Respondent's Name: SERVICE LLOYDS INSURANCE CO, BOX 42	Date of Injury: Employer's Name: REGENCY CONVERSIONS INC Insurance Carrier's No.: 9612799

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "This was the patient's initial evaluation to start physical therapy which is always performed before starting a physical therapy program – we even received pre-auth for physical therapy, so I don't understand why they would keep denying this date of service by having the therapist rebill."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's principle documentation did not include a Position Summary.

Principle Documentation:

1. DWC 60 response

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)
5-22-06	510/510	97001-59	1	$0.00
Total Due				$0.00

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, set out reimbursement guidelines.

1) The Respondent denied these services as "510-Payment determined. Pls have the therapist" [sic} rebill this charge." Per Rule 134.202 the doctor "or his representative" shall be listed in Box 31 of the CMS 1500. The "representative signed the Physical Therapy Evaluation which was submitted to the Division but did not sign the CMS 1500. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 134.1, 134.202

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 not entitled to reimbursement for the IRO and is not entitled to reimbursement for the services involved in this dispute.

Decision and Order by:

	Donna Auby, Medical Fee Dispute Officer	03-20-07
Authorized Signature	Typed Name	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.