Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Southeast Health Services P.O. Box 453062 Garland, TX 75045	MFDR Tracking #: M4-07-0549-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Dallas ISD Rep Box # 42	Date of Injury: Employer Name: Dallas ISD Insurance Carrier #: 2006036495

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services): "Code 97032 was denied ad "exceeds time limit" please see the attached documentation marked Exhibit #1 & #2 for clarification of this service."

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: Respondent did not submit a position summary.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
03/14/2006	W4V	97032 (x1 unit)	1-3	$19.58
Total Due:				$19.58

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, set out the reimbursement guidelines.

Per Rule 133.307 (d) (1) date of service 03/14/2006 was timely filed and is eligible for review.

1. These services were denied by the Respondent with reason code "W4V-No additional reimbursement allowed after review of appeal/reconsideration, medical records do not justify medical necessity of exceeding 60 minutes of physical therapy".

2. CPT code 97032 for date of service 03/14/2006, The MAR for this code is $20.50 ($16.40 x 125%) but the Requestor listed $19.58 on the Table of Disputed Services as their amount in dispute. The Requestor did obtain pre-authorization for this service per Rule 134.600. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or (2) health care providers usual and customary charge. Reimbursement in the amount of $19.58 is recommended.

3. Per review of Box 32 on CMS-1500, zip code 75217 is located in Dallas County.

4. A violation referral will be submitted to Legal & Compliance on the Respondent.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION 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 **$19.58** plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

07/13/2007

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.