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: Dr. Suhail Al-Sahli 1210A NASA Road 1 Houston, Texas 77058	MFDR Tracking #: M4-07-2352-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: BANKERS STANDARD INSURANCE COMPANY REP BOX #: 15	Date of Injury: Employer Name: United Electrical & Instrument Insurance Carrier #: 006430000898360

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary states in part: "…We have appealed to collect these charges from the insurance carrier because of an approved preauthorization for these services, but the carrier has failed to provide use with proper explanation for not paying for these services…."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Approval Letter dated 06/28/06

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the DWC 60.

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
07/05/06-07/21/06	X01, W12, W1, B6, Z3D	97545WH-CA x 1 unit x 8 Days	1 & 3	$1,024.00
07/05/06-07/21/06	X01, W12, W1, B6, Z3D	97546WH-CA x 6 hours x 8 Days	2 & 3	$3,012.00
Total Due:				$4,096.00

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.

A Benefit Review Conference was held on 03/09/04 to mediate resolution of the disputed issues. The parties were unable to reach an agreement.

A Contested Case Hearing was held on 05/12/04. It was determined by the Division that, "Claimant has been diagnosed as having an umbilical hernia. Claimant's umbilical hernia is causally related to his work activities on ___. Claimant sustained an injury, an umbilical hernia, in the course and scope of his employment on ___. The Requestor billed and treated for diagnosis code 553.1, UMB Hernia. On 05/12/04, the Appeals Panel did not issue a decision within the required time. The Decision of the hearing officer is final.

Per Rule 134.600(p)(4), a CARF accredited program does not require pre-authorization of services. The Requestor billed using modifier -CA indicating they are a CARF accredited facility. Per Rule 134.202 (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."

Preauthorization approval #7636 was given on 06/28/06 for Work Hardening/Conditioning Program, initial 2 hours and 78 additional hours, with a start date of 06/27/06 and an end date of 07/21/06.

Rule 134.600(c)(1)(B), states, "…The carrier is liable for all reasonable and necessary medical costs relating to the health care…listed in subsection (p) or (q) of this section only when the following situations occur…when ordered by the Commissioner' or (2) per subsection (r) of this section when voluntary certification was requ3sted and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section."

Rule 134.600(r), states, "…The carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and carrier and is documented."

1. This dispute is related to CPT code 97545 WH-CA x 1 unit for dates of service 07/05/06, 07/06/06, 07/07/06, 07/17/06, 07/18/06, 07/19/06, 07/20/06 and 07/21/06 denied with reason codes, "Z01—The procedure performed is not normally performed on patients wit the diagnosis given and/or the condition for which the patient is being treated"; "W12—Extent of injury. Not finally adjudicated"; "W1—Workers compensation state fee schedule adjustment"; "Z3D—Level II certified provider. (Z121 ANSI-B6)"; and "B6—This payment is adjusted when performed/billed by this type of provider, by this type of provider [sic], in this type of facility, or by a provider of this specialty." According to the ANSI code description, denial reason code "B6" is an inactive denial reason code effective 02/01/06, therefore, this is an inappropriate denial reason code by the Respondent. Per Rule 134.202(e)(5)(c)(i), the first two hours or each session shall be billed and reimbursed as one unit. Per Rule 134.202 (e)(5)(c)(ii) reimbursement shall be $64.00 per hour.

   * CPT code 97545-WH-CA x 1 unit = 2 hours x 8 Days = $1,024.00

2. This dispute is related to CPT code 97546 WH-CA x 6 hours for dates of service 07/05/06, 07/06/06, 07/07/06, 07/17/06, 07/18/06, 07/19/06, 07/20/06 and 07/21/06 denied with reason codes, "Z01—The procedure performed is not normally performed on patients wit the diagnosis given and/or the condition for which the patient is being treated"; W12—Extent of injury. Not finally adjudicated"; "W1—Workers compensation state fee schedule adjustment"; "Z3D—Level II certified provider. (Z121 ANSI-B6)" and "B6—This payment is adjusted when performed/billed by this type of provider, by this type of provider [sic], in this type of facility, or by a provider of this specialty." According to the ANSI code description, denial reason code "B6" is an inactive denial reason code effective 02/01/06, therefore, this is an inappropriate denial reason code by the Respondent. Per Rule 134.202 (e)(5)(c)(ii), reimbursement shall be $64.00 per hour.

   * CPT code 97546 WH-CA x 6 hours x 8 Days = $3,072.00

3. A referral has been made to Legal and Compliance against the Respondent for violation of Rule 134.600(c)(1)(D) and (r).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$4,096.00** plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

		06/14/07
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.