



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:  Charles Osborn, M.D., D.C. PO BOX 2597 WAXAHACHIE, TX 75168-8597	MFDR Tracking #: M4-07-2912-01
	DWC Claim #:
Respondent Name and Box #:  RED OAK ISD BOX 42	Injured Employee:
	Date of Injury:
	Employer Name: RED OAK ISD
	Insurance Carrier #: RO100204

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "It has come to my attention that your company is attempting to deny preauthorized medical care on the above referenced patient. According to your attached Explanation, your denial is based on medical necessity. This is not legal!..."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorizations

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No response was received from the Respondent.

### PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75168 is located in Ellis County.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
8-28-06 – 9-25-06 and 10-12-06 – 10-16-06	W9, 283	97110-GO (\$33.46 x 28 units)	1, 2, 3	\$936.88
8-28-06 – 9-25-06 and 10-12-06 – 10-16-06	W9, 283	97112-GO (\$34.56 x 14 units)	1, 2, 3	\$483.84
8-28-06 – 9-25-06 and 10-12-06 – 10-16-06	W9, 283	97530-GO (\$34.50 x 14 units)	1, 2, 3	\$483.00
<b>Total Due:</b>				<b>\$1,903.72</b>

### 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. These services were denied by the Respondent with reason code “283-Based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary,” and “W9-Unnecessary medical treatment based on peer review.”
2. Per Rule 134.600 (h), the Requestor provided a copy of preauthorization letters dated 8-24-06 and 10-11-06 for 21 sessions of Physical Therapy. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. 134.600 (c)(1)(B) (a) states "the Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title."
3. Reimbursement will be per Rule 134.202(c)(1).

A Legal and Compliance referral will be made for inappropriate denial of the preauthorized service per Rule 134.600 (c)(1)(B)

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

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

**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 \$1,903.72 plus accrued interest, due within 30 days of receipt of this Order.

**ORDER :**

Donna D. Auby

5-14-07

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.**