Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL 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: Alta Vista Health Care 5445 La Sierra Drive, Suite 204 Dallas, Texas 75231	MDR Tracking No.: M4-07-3154-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: SUA INSURANCE COMPANY REP BOX #: 17	Date of Injury: Employer's Name: Corporate Solutions, Inc. Insurance Carrier's No.: 875

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary states in part, "Enclosed are copies of the preauthorization letter, EOB and claim. The claim was denied and per EOB, 'This treatment falls under the responsibility of the treating physician per Rule 133.3.' The Services were preauthorized, #582894F0. The patient was referred by Dr. Dutra…In summary, it is our position that Attenta has established an unfair and unreasonable time frame in payment for the services that were authorized and rendered…"

Principle Documentation:
1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Approval Letter dated 01/24/06
5. Proof of Request for Reconsideration

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not provide a response to the DWC-60.

Principle Documentation:
1. N/A

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)
01/17/06	No EOBs	97750-FC X 4 Units	2 & 3	$142.04
05/04/06	No EOBs	97750 X 8 Units		$284.08
02/06/06	165	97032 X 2 Units X 9 DOS	1, 2 & 4	$37.88
02/08/06	18			$37.88
02/09/06	18			$37.88
02/13/06	18			$37.88
02/17/06	18			$37.88
02/22/06	18			$37.88
03/08/06	No EOBs			$37.88
03/09/06	No EOBs			$37.88
03/13/06	No EOBs			$37.88
02/06/06	165	97110-59 X 3 Units	1, 2 & 5	$100.38
02/08/06	18	97110-59 X 3 Units		$100.38
03/08/06	No EOBs	97110-59 X 2 Units		$66.92
03/09/06	No EOBs	97110-59 X 2 Units		$66.92

02/13/06 02/17/06 02/22/06 03/13/06	18 18 18 No EOBs	97110 X 3 Units 97110 X 3 Units 97110 X 3 Units 97110 X 2 Units	1, 2 & 6	$100.38 $100.38 $100.38 $66.92
02/06/06	165	A4556-NU	2 & 7	$15.19
02/09/06 03/08/06 03/09/06 03/13/06	18 No EOBs No EOBs No EOBs	97530 X 3 Units X 4 DOS	1, 2 & 8	$103.50 $103.50 $103.50 $103.50
TOTAL DUE				$1,898.89

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, sets out reimbursement guidelines.

1. Per Rule 134.600, the Requestor submitted a copy of the Respondent's preauthorization letter indicating authorization # 582894-F-0, as proof that preauthorization approved on 01/24/06 for Occupational Therapy, three (3) times per week for three (3) weeks with no start date or end date indicated.

2. Neither the Requestor nor the Respondent submitted EOBs for CPT code 97750-FC for date of service 01/17/06; 97750-FC for date of service 05/04/06; CPT code 97032 for dates of service 03/08/06, 03/09/06 and 03/13/06; CPT code 97110-59 for dates of service 03/08/06 and 03/09/06; CPT code 97110 for date of service 03/13/06; and CPT code 97530 for dates of service 03/08/06, 03/09/06 and 03/13/06, therefore, per Rule 133.307 (e)(2)(b), these dates of service will be reviewed and reimbursed MAR according to the 2002 Medical Fee Guideline. The remaining CPT codes were denied with reason codes "165—Payment denied/reduced for absence of or exceeded referral" ; and "18—Duplicate claim/service."

3. This dispute relates to CPT code 97750-FC x 4 Units for date of service 01/17/06 and 97750-FC X 8 Units for date of service 05/04/06. The Respondent reimbursed the Requestor $00.00. Per Rule 134.202 (b) and (c)(1), reimbursement in the amount of **$426.12** ($28.41 x 125% x 12 Units) is recommended.

4. This dispute relates to CPT code 97032 for date of service 02/06/06 that was denied as "165—Payment denied/reduced for absence of, or exceeded referral", dates of service 02/08/06, 02/09/06, 02/13/06, 02/17/06 and 02/22/06 was denied as "18—Duplicate claim/service." No EOB's were provided for remaining dates of service 03/08/06, 03/09/06 and 03/13/06, therefore, per Rule 133.307 (c)(2)(b), this date of service will be reviewed and reimbursed MAR according to the 2002 Medical Fee Guideline. Per Rule 134.202 (d), reimbursement in the amount**$340.92** ($15.15 x 125% x 2 Units x 9 DOS) is recommended.

5. This dispute relates to CPT code 97110-59 for date of service 02/06/06 that was denied as "165—Payment denied/reduced for absence of, or exceeded referral", date of service 02/08/06 was denied as "18—Duplicate claim/service." No EOB's were provided for remaining dates of service 03/08/06 and 03/09/06. Per Rule 134.202 (b) and (c)(1), reimbursement in the amount of **$334.60** ($29.40 x 125%x 10 Units) is recommended.

6. This dispute relates to CPT code 97110 for dates of service 02/13/06, 02/17/06 and 02/22/06 that were denied as "18—Duplicate claim/service." No EOB's were provided for remaining date of service 03/13/06. Per Rule 134.202 (d), reimbursement in the amount of **$368.06** ($29.40 x 125% x 11 Units)is recommended.

7. This dispute relates to HCPCS code A4556-NU for date of service 02/06/06 that was denied as "165—Payment denied/reduced for absence of, or exceeded referral". Per Rule 134.202 (b) and (c)(1), and Palmetto GAB 2006 DME Fee Schedule, reimbursement in the amount of **$15.19** ($12.15 x 125%) is recommended.

8. This dispute relates to CPT code 97530 for date of service 02/09/06 that was denied as "18—Duplicate claim/service." No EOB's were provided for remaining dates of service 03/08/06, 03/09/06 and 03/13/06. Per Rule 134.202 (d), reimbursement in the amount of **$414.00** ($29.40 x 125% x 3 Units x 4 DOS) is recommended.

9. Therefore, per Rule 134.202 (d)(2) and the Requestor's Table of Disputed Services, reimbursement in the amount of **$1,898.89**, is recommended

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600, §133.307

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 in the amount of $1,898.89 plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	06/20/07 Date of Order

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.