**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:<br>Matrix Rehabilitation Texas<br>P. O. Box 11407, Drawer 1224<br>Birmingham, Alabama 35246-1224 | MDR Tracking No.: M4-07-3171-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name and Address:<br>State Office of Risk Management<br><br>Rep Box # 45 | Date of Injury:<br>Employer's Name: State of Texas<br>Insurance Carrier's No.: WC2407963 |

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

The Requestor's Position Summary as indicated on the Table of Disputed Services states, "Attached is a letter from Forte dated 4-5-06 approving treatment with authorization # 590807. The claim denied for no authorization."

Principle Documentation:
1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Medical Records

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

The Respondent's Position Summary as indicated on the Table of Disputed Services states, "The Office will maintain denial of the charges in disputed based on no preauthorization. A preauth request was received on 4/4/06 from the requestor however the verbal preauth was issued on 4/7/06 and written approval issues on 4/10/06 as evidenced by the attached notification report."

Principle Documentation:
1. Response to DWC 60
2. Preauthorization Approval Letter dated 04/10/06

## 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) |
|---|---|---|---|---|
| 04/05/06 | 62/R1,W4 | 97110 | 1&2 | $00.00 |
| 04/05/06 | 62/R1,W4 | 97140 | 1&2 | $00.00 |
| TOTAL DUE | | | | $00.00 |

## 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, sets out reimbursement guidelines.

1. This dispute relates to CPT code 97110 and CPT code 97140 for date of service 04/05/06 that was denied as "62—Pre-certification/authorization absent or exceeded (Verbal pre-auth for PT wasn't given until 4/7/06), R1—Duplicate billing, and W4—No additional payment allowed after review".

2. The Respondent's submitted preauthorization approval letter, authorization # 590807 F 0, dated 04/10/06 for physical therapy, three (3) times a week for four (4) weeks for a total of twelve (12) sessions. The disputed services were rendered on 04/05/06, prior to the preauthorization approval date; therefore, per Rule 134.600 reimbursement is not recommended.

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

Texas Labor Code, Section §413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §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 not entitled to reimbursement.

**Findings & Decision by:**

| | | 05/03/07 |
|---|---|---|
| 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.**