



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION AND ORDER

PART I: GENERAL INFORMATION

Requestor's Name and Address: Trinity Phy-Med P O Box 453062 Garland, Texas 75045	MFDR Tracking #: M4-07-3288-01
	DWC Claim #:
	Injured Employee:
Respondent Name: Insurance Company of the State of PA Box #: 19	Date of Injury:
	Employer Name: AMR Corp
	Insurance Carrier #: 56601207

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "This visit denied as "preauthorization being exceeded or not being approved." This is an error...All fax confirmations and corresponding cover sheets."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a position summary to MDR.

Principle Documentation: The Respondent did not submit a response to the DWC 60.

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76021 is located in Tarrant county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
02-08-06 and 02-22-06	W9	97110 (\$33.39 x 6 units)	1, 5 & 6	\$200.34
02-14-06, 03-02-06, 03-10-06 and 03-13-06	62	97110 (\$33.39 x 12 units)	2 & 6	\$400.68
02-24-06	17	97110-59	3 & 4	\$0.00
Total Due:				\$601.02

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code 402.00128(b)(7) titled *General Powers and Duties of Commissioner* authorizes the Commissioner to enter appropriate orders. The Division will resolve medical fee disputes according to Rules 133.305, 133.307, 134.801 (c)(2) and other rules. In addition, 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.

Per Rule 133.307(c)(1)(A) dates of service 01-13-06 and 01-18-06 were not timely filed and are ineligible for review.

1. These services were denied by the Respondent with reason code "W9" (unnecessary med treatment based on peer review. Peer review obtained by the carrier ind treatment to be medically unreasonable and/or unnecessary and documented srcv does not meet fee guide contained W/I appli AMA CPT/HJCPCS Guide).

2. These services were denied by the Respondent with reason code "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-certification). The Requestor obtained preauthorization (H4909144740) for CPT code 97110 X 6 to cover dates of service 03-02-06 through 04-02-06.
3. This service was denied by the Respondent with reason code "17" (a healthcare provider shall not submit a medical bill later than the ninety fifth day after the date the services are provided for services provided on or after September 1, 2005. Rule 134.801 Section C).
4. The Requestor provided written documentation to the Division supporting that Form CMS-1500 was submitted timely to the carrier. Specifically, the Requestor submitted a CMS-1500 dated 03-23-06 in Block #31. The DWC-67 instructions for completing the CMS-1500, directs the healthcare provider to notate in block 31 the date the claim is submitted to the carrier. The medical bill was timely submitted.
5. The Requestor obtained preauthorization (H4909136244) for CPT code 97110 X 12 to cover dates of service 01-26-06 through 02-26-06 prior to the services being rendered. The Respondent is in violation of Rule 133.301(a) which states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title".
6. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge." Reimbursement is recommended in the amount of \$601.02 (1 unit @ \$33.39 X 18 units).

A Legal and Compliance referral is made due to the Respondent being in violation of Rules 133.301(a) and 134.801(c)(2).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §402.00128(b)(7)
 Texas Labor Code Sec. §413.011(a-d)
 28 Texas Administrative Code Sec. §134.1
 28 Texas Administrative Code Sec. §134.202
 28 Texas Administrative Code Sec. §134.801 effective 9/1/05
 28 Texas Administrative Code Sec. §133.301

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 \$601.02 plus accrued interest, due within 30 days of receipt of this Order.

The Division hereby orders the Respondent to process the bill(s) and issue a new EOB for all services included in the original bill(s) within 21 days of receiving this Order.

DECISION AND ORDER:

05-23-07

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.

If Requestor is dissatisfied with the Respondent's final action on a medical bill, the Requestor may request medical dispute resolution in accordance with Rule 133.305 as long as the request is filed within the appropriate timeframe.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.