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: Nestor Martinez, D.C. 6660 Airline Drive Houston, Texas 77076	MFDR Tracking #: M4-07-3380-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: GRAY INSURANCE COMPANY REP BOX #: 19	Date of Injury: Employer Name: G T Leach Builders, LLC Insurance Carrier #: 2005000707

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…our facility had pre-authorization for these services and no where on the pre-authorization letter it specifies length of time."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Approval Letter dated 06/12/06
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The current dispute involves dates of service from 06/12/06-06/30/06. As noted in the carrier's EOBs, a usual treatment session is not more than 60 minutes according to Trailblazer LCD Y-18B. Here the 97110 therapeutic exercises alone was 5 units or 1.25 hours. Moreover in addition to an office visit, 1.25 hours of therapeutic exercises, and neuromuscular reeducation, the provider attempted to include 30 minutes of manual therapy. As noted in the carrier's denial, the claimant's injuries have not been documented to justify this level of attention. Pre-authorization is not a blank check allowing the provider to violate the spirit and the letter of the fee guidelines…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
06/12/06 through 06/30/06	151	97110 X 1 Unit X 9 Days	1 – 5	$322.74
06/12/06 through 06/30/06	151	97140 X 2 Units X 9 Days	1 – 5	$599.94
Total Due:				$922.68

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. This dispute is related to CPT codes 97110 x 1 Unit and 97140 x 2 Units for dates of service 06/12/06, 06/13/06, 06/14/06, 06/19/06, 06/21/06, 06/22/06, 06/26/06, 06/27/06 and 06/30/06 that was denied with reason code "151—Payment adjusted because the payer deems the information submitted does not support this many services. The usual treatment session is not more than 60 minutes per Trailblazerhealth LCD Y-18B, effective 1/1/06."

2. Preauthorization approval # 596538 F 1 was given on 06/12/06 for Physical Therapy, three (3) times a week for four (4) weeks, to consist of therapeutic exercises, neuromuscular reeducation, manual therapy, electrical stimulation and ice/heat, with no start date or end date indicated.

3. Rule 134.600(c)(i)(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…preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care…"

4. Per 134.202(b) and (c)(1), it is the conclusion of the Division that reimbursement is as follows:

   CPT Code 97110--$322.74 ($28.69 x 125% x 1 Unit X 9 Days); and
   CPT Code 97140--$599.94 ($26.66 x 125% x 2 Units X 9 Days)
   TOTAL: **$922.68**

5. A referral was made to Legal and Compliance against the Respondent for violation of Rule 134.600(c)(i)(B).

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, §133.307 (effective 12/31/06)

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 **$922.68** plus accrued interest, due within 30 days of receipt of this Order.

Decision:

04/13/07

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.