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's Name and Address: Ergonomic Rehabilitation of Houston 283 Lockhaven Drive Suite 315 Houston, Texas 77073	MFDR Tracking #:	M4-07-3424-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name: Harris County Hospital District Box #: 42	Date of Injury:	
	Employer Name:	Harris County Hospital District
	Insurance Carrier #:	HC200502

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Our charges for the disputed dates of service were denied based on ANSI code 131, 213 and 151. The explanation of the insurance company for this reason is the treatment exceeds 45 minutes of physical therapy."

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

Respondent's Position Summary: No position summary was submitted by the Respondent with their response.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77031 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
2-06-06 to 4-6-06	151, 397, 213	97110 (1 unit @ $35.86 x 126 = $4,518.36 minus carrier payment of $2814.81 = $1,703.55 minus $66.73 (see note below) = $1,636.82)	1 - 3	$1,636.82
		Note: Per Rule 134.202(c)(1) the Requestor is allowed additional reimbursement of $1,703.55; however, for dates of service 05-31-06, 06-01-06, 06-05-06, 06-07-06, 06-16-06, 06-19-06 and 06-23-06 the Requestor listed a total of $66.73 less in dispute on the Table of Disputed Services.		

3-24-06, 3-27-06, 3-29-06, 4-04-06, 4-05-06, 4-06-06	151, 397, 213	97035 (1 unit @ $15.53 x 6 DOS)	1 - 3	$93.18
Total Due:				$1,730.00

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 codes:
   - 151 - Payment adjusted because the payer deems the information submitted does not support this many services.
   - 397 - Allowance is based on utilization review pre-authorizations.
   - 213 - The charge exceeds the scheduled value and/or parameters that would appear reasonable.
   - W1 - Workers Compensation State Fee Schedule Adjustment.

   With regard to ANSI reason code 151 the Division will clarify whether the code shall be used for medical necessity or fee denials. The Division review will determine the dispute track.

2. The Requestor obtained preauthorizations (# 198414, 201227, 203166 & 208243) authorizing a total of 44 sessions of physical therapy with a planned or recommended start date of 02-03-06 and a planned or recommended end date of 06-23-06. The Requestor listed 31 dates of service as being in dispute. The Respondent is in violation of Rule 134.600(c)(1)(B) which states in part "The carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care".

3. Reimbursement per Rule 134.202(c)(1) is recommended in the following amounts: CPT code 97110 $1636.82 (1 unit @ $35.86 x 126 units = $4,518.36 minus Respondent payment of $2,814.81 = $1,703.55 minus $66.73 (see note above in Section IV) and CPT code 97035 $93.18 (1 unit @ $15.53 x 6 DOS).

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202 and §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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $1,730.00 plus accrued interest, due within 30 days of receipt of this Order

ORDER:

		05-31-07
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.