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 #: M4-07-3626-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE COMPANY REP BOX #: 19	Date of Injury: Employer Name: ISI Specialists, Inc. Insurance Carrier #: 2230131187

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Our facility had pre-authorization for these services."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Medical Records
5. Preauthorization Approval Letter dated 08/09/06

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The Carrier has correctly reimbursed the provider for the disputed services. Carrier has based its reimbursement upon interpretation of the current Fee Guidelines, as well as review of the documentation submitted to support that the services were performed. While it appears the provider obtained preauthorization for 10 sessions of WC, Carrier asserts the documentation submitted does not support that these are the services provided on 8/29 and 8/30/2006, and that the Carrier has correctly reimbursed the provider for the services that were provided…"

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
08/29/06 08/30/06	W1, 790/18, 224	97546-WC x 5 Units x 2 Days	1 & 2	$144.00 $144.00
Total Due:				$288.00

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. This dispute is related to CPT code 97546-WC x 5 Units for dates of service 08/29/06 and 08/30/06 that were denied with reason codes "W1—Workers Compensation State Fee Schedule Adjustment; "790—This charge was reimbursed in accordance to the Texas Medical Fee Guideline; "18—Duplicate claim/service'; and "224—Duplicate charge." Preauthorization approval #060809-064805 was given on 08/09/06 for a Work Conditioning Program, ten (10 Visits), with a start date of 08/08/06 and an end date of 10/06/06. 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…" Rule 133.307(j)(2) specifically states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and other party. Response shall not address new or additional denial reasons or references after the filing of the request. Any new denial reasons or references raised shall not be considered in the review." The Requestor's submitted documentation clearly supports services were rendered as billed. Per Rule 134.202(e)(5)(B)(ii), a Non-CARF accredited program shall be reimbursed at 80% of the MAR. Reimbursement is recommended in the amount of **$288.00 ($36.00 x 80% = $28.80 per hour (MAR) X 5 hours = $144.00 X 2 Days = $288.00)**.

2. 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 **$288.00** plus accrued interest, due within 30 days of receipt of this Order.

Decision:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Debra Hausenfluck	04/05/07

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.