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

Type of Requestor: (x) Health Care Provider( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Velma Jackson, P.T. 5445 Almeda Road. Suite 303 Houston, TX 77004	MDR Tracking No.: M4-07-3839-01 Claim No.: Injured Employee's Name:
Respondent's Name: Harris County Hospital District Box 42	Date of Injury: Employer's Name: Harris County Hospital District Insurance Carrier # HD200677

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

Requestor's Position Summary states in part, "This claim is being disputed because of appropriate treatment given, and was pre-authorized."

Principle Documentation:
1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Respondent did not submit a Position Summary to MFDR.

Principle Documentation: 1. Response to DWC 60

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)
06/15/06 – 07/12/06	151,397,213	97035	1, 2	$155.25
06/15/06 – 07/12/06	151,397,213	97110	3, 4	$35.86
TOTAL DUE				$191.11

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. CPT code 97035 billed for dates of service 06/15/06 – 07/12/06 was denied by carrier with denial codes "151" (Payment adjusted because the payer deems the information submitted does not support this many services), and "213" (The charge exceeds the scheduled value and parameters that would appear reasonable.)

2. Requestor received Pre-Authorization for 18 sessions of Physical Therapy between 06/12/06 – 07/31/06 under UR Review #209674 on 06/13/06. Requestor complied with these guidelines. Per Rule 134.600 (c) (1) (B) The carrier is liable for all reasonable and necessary medical costs relating to the health care and for preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care, therefore, reimbursement is recommended in the amount of **$155.25 ($12.42 X 125% = $15.52 X 10 (Units) = $155.25).**

3. CPT code 97110 billed for dates of service 06/15/06 – 07/12/06 was denied by carrier with denial 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-authorization.) and "213" (The charge exceeds the scheduled value and parameters that would appear reasonable.).

4. Requestor received Pre-Authorization for 18 sessions of Physical Therapy between 06/12/06 – 07/31/06 under UR Review #209674 on 06/13/06. Requestor complied with these guidelines. Per Rule 134.600 (c)(1)(B) The carrier is liable for all reasonable and necessary medical costs relating to the health care and for preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care reimbursement is recommended in the amount of **$35.86 ($28.69 X 125% = $35.86)**.

CPT codes 97035 & 97110 were denied for medical necessity after pre-authorization was obtained, therefore, a Legal & Compliance Referral has been made against the Respondent for violation of rule 134.600 (c)(1)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202 133.307(eff.12/31/06)

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 additional reimbursement in the amount of **$191.11.** The Division hereby ORDERS the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Eileen V. Atkinson	04/11/07
Authorized Signature	Medical Dispute Officer	Date of Order

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.