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 77037	MFDR Tracking #: M4-07-3931-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: HOUSTON I. S. D. REP BOX #: 21	Date of Injury: Employer Name: Houston I. S. D. Insurance Carrier #: 26117252

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 1500
3. EOB
4. Preauthorization Approval Letter dated 09/29/06

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent's response to the DWC 60 did not include a position summary.

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
10/03/06 thru 10/19/06	62, 171, W1	97545-WH x 1 Unit x 8 Days	1, 2 & 5	$ 819.20
10/03/06	62, 171, W1	97546-WH x 4 Hours x 1 Day	1, 3 & 5	$ 204.80
10/04/06 thru 10/19/06	62, 171, W1	97546-WH x 5 Hours x 7 Days	1, 3 & 5	$1,792.00
Total Due:				$2,816.00

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 97545-WH x 1 Unit for dates of service 10/03/06, 10/04/06, 10/09/06, 10/10/06, 10/16/06, 10/17/06, 10/18/06 and 10/19/06 that were denied with reason codes "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization" "172—Payment is adjusted when performed/billed by a provider of this specialty" and "W1—Workers Compensation State Fee Schedule Adjustment."

2. Preauthorization approval #06PH07008 was given on 09/29/06 for a Work Hardening Program, with a start date of 09/26/06 and an end date of 11/10/06. 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…" Per Rule 134.202(e)(5)(A)(ii), A Non-CARF accredited program shall be reimbursed at 80% of the MAR. Per Rule 134.202(5)(c)(i), the first two hours or each session shall be billed and reimbursed as one unit; therefore, reimbursement is recommended in the amount of **$819.20 ($64.00 x 80% = $51.20 per hour (MAR) X 2 hours = $102.40 x (1 Unit) x 8 Days = $819.20)**.

3. This dispute is related to CPT code 97546 WH X 4 Hours for date of service 10/03/06 and 97546 WH x 5 Hours for dates of service 10/04/06, 10/09/06, 10/10/06, 10/16/06, 10/17/06, 10/18/06 and 10/19/06 that were denied with reason codes "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization" "172—Payment is adjusted when performed/billed by a provider of this specialty" and "W1—Workers Compensation State Fee Schedule Adjustment."

4. Preauthorization approval #06PH07008 was given on 09/29/06 for a Work Hardening Program, with a start date of 09/26/06 and an end date of 11/10/06. 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…" Per Rule 134.202(e)(5)(A)(ii), A Non-CARF accredited program shall be reimbursed at 80% of the MAR. Reimbursement is recommended in the amount of **$1,996.80 ($64.00 x 80% = $51.20 per hour (MAR) x 4 Hours = $204.80 X 1 Day = $204.80 and $64.00 x 80% = $51.20 per hour (MAR) x 5 Hours = $256.00 x 7 Days = $1,792.00 for a total of $1,996.80)**.

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 **$2,816.00** plus accrued interest, due within 30 days of receipt of this Order.

Decision:

04/09/07

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.