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: Alta Vista Healthcare 5445 La Sierra # 204 Dallas, TX 75231	MFDR Tracking #: M4-07-4409-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Hartford Casualty Insurance Co. Rep Box# 27	Date of Injury: Employer Name: Alamo Truss & Components Insurance Carrier #: YLLC08104

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…It is our position that Hartford has established an unfair and unreasonable time frame in paying for the services that were medically necessary…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a position summary.

Principle Documentation: N/A

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
03/30/06	W1	97750-Physical Performance Test	1	$319.59
03/30/06	W1	95851-Range Of Motion	2	$00.00
08/08/06	62	97545-WH-CA	3	$128.00
08/08/06	62	97546-WH-CA	4	$384.00
Total Due:				$831.59

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 relates to CPT code 97750 for date of service 03/30/06 with reason code "W1- WC State Fee Schedule Adjustment. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid

at this time". The Requestor submitted the delivery confirmation showing request for reconsideration was submitted to the carrier. The carrier did not respond. Therefore per Rule 134.202 (c) (1) reimbursement in the amount of $319.59 ($28.41 x 125% =$35.51 x 9 units) is recommended.

2. This dispute relates to CPT code 95851 for date of service 03/30/06 with reason code "W1-WC State Fee Schedule Adjustment. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time". According to Rule 134.202 (b) this code is considered by Medicare to be a component procedure of another code 97750 which was performed on the same date of service. Therefore reimbursement is not recommended.

3. This dispute relates to CPT code 97545-WH-CA for date of service 08/08/06 denied with "62-Payment denied/reduced for absence of or exceeded pre-certification/authorization. Procedure not approved by pre-authorization". The facility is CARF accredited and therefore the services do not require preauthorization. Per Rule 134.202 (e) (C) (i) (ii), A CARF accredited program shall be reimbursed at $64.00 per hour. Reimbursement is recommended in the amount of $128.00 ($64.00 x 2).

4. This dispute relates to CPT code 97546-WH-CA for date of service 08/08/06 denied with "62-Payment denied/reduced for absence of or exceeded pre-certification/authorization. Procedure not approved by pre-authorization". The facility is CARF accredited and therefore the services do not require preauthorization. Per Rule 134.202 (e) (C) (i) (ii), A CARF accredited program shall be reimbursed at $64.00 per hour. Reimbursement is recommended in the amount of $384.00 ($64.00 x 6).

5. CPT Codes **97750** for dates of service 03/14, & 07/31/06, **97545-WH-WC, 97546-WH-WC** dates of service 08/07, 08/10, 08/17 & 10/13/06, **97750** for dates of service 08/21 & 09/05/06, Were withdrawn by the Requestor on 03/19/07 and will not be included in the review.

6. A referral will be submitted to Legal & Compliance.

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
28 Texas Administrative Code Sec. §133.307

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 **$831.59** plus accrued interest, due within 30 days of receipt of this Order.

Decision:

04/13/2007

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.