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: Rehabilitation Institute of South Texas P O BOX 6208 McAllen, Texas 78502	MFDR Tracking #:	M4-07-4517-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name: Dallas National Insurance Box #: 20	Date of Injury:	
	Employer Name:	AMS Staff Leasing NA Inc.
	Insurance Carrier #:	A27263

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "preauthorized services denied...the first 9 sessions have been paid."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary submitted by the Respondent to MFDR.

Principle Documentation: No response to the DWC 60 submitted by the Respondent to MFDR

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78504 is located in Hidalgo county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
06-15-06, 06-20-06 and 06-22-06	50	97010	1	$0.00
06-15-06, 06-20-06 and 06-22-06	50	G0283 (1 unit @ $13.58 X 3 units)	2 - 4	$40.74
06-15-06, 06-20-06 and 06-22-06	50	97140 (1 unit @ $31.15 X 3 units)	2 – 4	$93.45
06-15-06, 06-20-06 and 06-22-06	50	97110 (1 unit @ $33.46 X 10 units)	2 - 4	$334.60
Total Due:				$468.79

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 code "50" (these are non-covered services because this is not deemed a 'medical necessity' by the payer.) Code 97010 is a bundled service code and considered to b e an integral part of a therapeutic procedure(s). Reimbursement is included in the reimbursement for the comprehensive therapeutic code. Therefore, reimbursement is not recommended.

2. These services were denied by the Respondent with reason code "50" (these are non-covered services because this is not deemed a 'medical necessity' by the payer).

3. The Requestor obtained preauthorization (authorization # 40777) for CPT code G0283 for 12 sessions (3 per week for 4 weeks) for dates of service 05-22-06 through 06-22-06 and preauthorization (authorization # 40777-IC) for CPT codes 97140, 97110 and 97035 for 12 sessions (3 per week for 4 weeks) for dates of service 05-22-06 through 06-22-06. The Respondent is in violation of Rule 134.600(c)(1)(B) which states "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."

4. Reimbursement is recommended Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge" in the following amounts: CPT code G0283 - $40.74 ($13.58 X 3), CPT code 97140 - $93.45)$31.15 X 3) and CPT code 97110 - $334.60 ($33.46 X 10).

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600(c)(1)(B) as referenced in number three (3) above.

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 $468.79 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05-16-07
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.