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: The Neuromuscular Institute of Texas, P.A. 9502 Computer Drive, Suite 100 San Antonio, Texas 78229	MFDR Tracking #: M4-07-4707-01 DWC Claim #: Injured Employee:
Respondent Name: AT & T Box #: 19	Date of Injury: Employer Name: AT & T Insurance Carrier #: 4650167372

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: No position summary submitted by the Requestor

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: "In conclusion, the Respondent has paid for the specific services that were preauthorized. All other services were denied as not medically necessary and do not fall under the jurisdiction of Medical Dispute Resolution. Therefore, this dispute should be dismissed."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78229 is located in Bexar county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
04-13-06 & 04-17-06	W1, 45, 147, 50, 97	97140-59 (1 unit @ $31.15 x 2 DOS)	1 - 4	$62.30
04-13-06 & 04-17-06	97, 50	97035-GP (1 unit @ $14.59 x 2 DOS)	1 - 4	$29.18
04-17-06	W1, 45, 50	97110-GP (1 unit)	1, 2 & 4	$33.46
06-26-06	147, 97	99080-CC	1 & 5	$00.00
Total Due:				$124.94

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.

The Requestor submitted an updated Table of Disputed Services to MFDR on 05-16-07 which is used for the review. The remaining dates of service in dispute include 04-13-06, 04-17-06 and 06-26-06.

1. The service/services in dispute was/were denied by the Respondent with the reason code/codes listed below:
    - W1 (These are non-covered services because this is not deemed a 'medical necessity' by the payer).
    - 45 (These are non-covered services because this is not deemed a 'medical necessity' by the payer).
    - 147 (These are non-covered services because this is not deemed a 'medical necessity' by the payer).
    - 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer).
    - 97 (Payment is included in the allowance for another service/procedure).

2. The Requestor obtained preauthorization (# 1705014) authorizing outpatient, additional occupational therapy for the left arm and wrist at 3 times a week for 2 weeks for the time frame from 4-5-06 to 4-21-06. The Respondent is in violation of Rule 133.301(a) which states in part "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title".

3. Per Rule 134.202(b) CPT codes 97140 and 97035 are not included in the allowance for another service/procedure billed on the dates of service in dispute.

4. Reimbursement per Rule 134.202(c)(1) is recommended in the following amounts: CPT code 97140-59 $62.30 (1 unit @ $31.15 x 2 DOS), CPT code 97035-GP $29.18 (1 unit @ $14.59 x 2 DOS), CPT code 97110-GP $33.46.

5. Per Rule 134.202(b) CPT code 99080 is a bundled code; therefore no reimbursement is recommended.

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 133.301(a).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202 and §133.301

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 $124.94 plus accrued interest, due within 30 days of receipt of this Order

ORDER:

		05-25-07
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.