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: Dipti Patel, D.C. 6660 Airline Drive Houston, Texas 77076	MFDR Tracking #:	M4-07-4798-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name: Fidelity & Guaranty Insurance	Date of Injury:	
Box #: 19	Employer Name:	Convergys Corporation
	Insurance Carrier #:	3471098820

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Our facility had pre-authorization for these services. Our facility has not exceeded any fee schedule."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The current dispute involves charges for therapy performed from 12/12/06-01/05/07. These charges were reviewed and reduced in accordance with the applicable fee guidelines. Carrier has attached EOBs setting addressing the basis for the reductions."

Principle Documentation: Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77076 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
12-12-06 to 12-21-06	151PI, 213, & 42MA	97140 (1 unit @ $33.33 x 12 units - payment)	1 - 3	$333.31
01-02-07 to 01-05-07	151PI, 213, & 42MA	97140 (1 unit @ $31.89 x 6 units)	1 - 3	$191.34
Total Due:				$524.65

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 "151PI" (Payment adjusted because the payer deems the information submitted does not support this many services). The Division clarifies reason code 151 shall be used for medical necessity or fee denials. Division review will determine the dispute track. The services were also denied with reason code "213" (The charge exceeds the scheduled value and/or parameters that would appear reasonable) and/or reason code "42MA" (Charges exceed our fee schedule or maximum allowable amount). The Requestor made a partial payment of $33.32 for date of service 12-12-06 and $33.33 for date of service 12-18-06.

2. The Requestor obtained preauthorization (# 9685121) on 12-1-06 preauthorizing outpatient physical therapy to lumbar spine 3 times per week times 4 weeks (12 visits) and preauthorization (# 96851229) on 12-29-06 continuing outpatient physical therapy to lumbar spine 3 times per week times 4 weeks (12 visits). The Respondent denied the services because the payer deemed the information submitted did not support this many services (medical necessity). The Respondent is in violation of Rule 134.600(c)(1)(B) which states in part "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: preauthorization of any health care in subsection (h) of this section was approved prior to providing the health care."

3. Reimbursement is recommended per Rule 134.202(c)(1) in the following amounts: Dates of service in 2006 $333.31 ($33.33 x 12 units billed = $399.96 minus payment of $66.65) and dates of service 2007 $191.34 ($1 unit @ $31.89 x 6 units).

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600.

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 $524.65 plus accrued interest, due within 30 days of receipt of this Order

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		05-24-07

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.