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: Valley Spine Medical Center 5327 S. McColl Road Edinburg, Texas 78539	MFDR Tracking #: M4-07-4817-01 DWC Claim #: Injured Employee:
Respondent Name: American Home Assurance Box #: 19	Date of Injury: Employer Name: Willies Appliance & Furniture Insurance Carrier #: 710166123

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Pre-authorization approval for the chronic pain program 160 hrs. PA # 028796201. The care rendered to the patient has meet criteria set by Texas Labor Code Section 408.21…"

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: "This dispute involves DOS 04/04/06 through 07/26/06 and has $5,319.00 in dispute. The bills were denied as duplicative or insufficiently documented to justify reimbursement."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78539 is located in Hidalgo county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
05-16-06, 05-17-06 05-18-06 & 05-19-06	50, W1 & 18	97799-CP (1 hour @ $100.00 X 8 hours X 4 DOS)	1, 3 & 4	$3,200.00
06-15-06 & 06-20-06	50, W1 & W4	97799-CP (1 hour @ $100.00 X 8 hours X 2 DOS)	2, 3 & 4	$1,600.00
Total Due:				$4,800.00

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.

The Requestor withdrew dates of service 04-04-06 and 07-26-06 from the dispute.

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) and "W1" (Workers Compensation State Fee Schedule Adjustment) and "18" (duplicate claim/service).

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) and "W1" (Workers Compensation State Fee Schedule Adjustment) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration).

3. The Requestor obtained preauthorization (certification number 028796201) preauthorizing chronic pain management (160 hours) with a begin date of 04-28-2006 and an expiration date of 07-15-2006 prior to the services being rendered. 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: 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(e)(5)(A)(ii) and 134.202(e)(5)(E)(i) in the following amount: **$4,800.00 (1 hour @ $100.00 X 48 hours).**

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600 as referenced in number 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 $4,800.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05-24-06
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.