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: Memorial MRI & Diagnostics 1346 Campbell Road Houston, Texas 77055	MFDR Tracking #: M4-07-4844-01 DWC Claim #: Injured Employee:
Respondent Name: American Home Assurance Co. Box #: 19	Date of Injury: Employer Name: Wal Mart Stores Inc. Insurance Carrier #: C6224951

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "medicare payable and the CCI edit permit payment with use of modifier – 51."

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: "As a result of the review, the procedure was denied with ANSI "97" as the procedure is included in another service. No additional allowance is recommended."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77055 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
09-08-06	50, 42, 5059, 309, 97 & 243	36000-51	1 - 3	$29.33
Total Due:				

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), "42" (charges exceed our fee schedule or maximum allowable amount), "5059" (based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters, refer to doctor report), "309" (the charge for this procedure exceeds the fee schedule allowable), "97" (payment is included in the allowance for another service/procedure) and "243" (the charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed. The Respondent has not made a payment to the Requestor.

2. The Requestor obtained preauthorization (number 5250-188278) with notification date of 09-05-06 preauthorizing CPT codes 62282, 72275, 76000, 72132, **36000,** 99244, 99144, 76377/Lumbar ESI #1 with a start date of 09/05/06 and an end date of 10/05/06. 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". Per Rule 134.202(b), CPT code 36000 is considered a component procedure of CPT codes 62282, 76000, 99144 and 90765 also billed on date of service 09-08-06. A modifier is allowed to differentiate between services provided and separate payment is considered justifiable if an appropriate modifier is used. The Requestor billed with an appropriate modifier (51).

3. 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." Reimbursement is recommended in the amount of $29.33.

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600 as referenced in number 2 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 **$29.33** 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.