Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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: Neuromuscular Institute of Texas – P. A. 9502 Computer Drive, Suite 100 San Antonio, TX 78229	MFDR Tracking #: M4-07-4919-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO BOX 19	Date of Injury: Employer Name: ADMINISTAFF INC Insurance Carrier #: YLLC07521

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Medical review Institute of America, an independent IRO agency authorized upon appeal 17 visits of physical therapy on May 9, 2006. On May 24, 2006, Genex, which is affiliated with SRS/Hartford, approved 12 visits of physical therapy. As far as I am aware, the approvals were for two different requests submitted by our office."

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

No Position Summary was submitted by the Respondent.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
8-17-06	W9 or 50	99080-CC ($.50 x 48 units)	1	$24.00
4-20-06 – 7-17-06	W9 or 50	90806 ($113.55<MAR x 11 units)	1, 2, 5, 6	$1,249.05
5-9-06	W9 or 50	L1846-BR	1, 3	Pay per Rule 134.202 (c)(6)
5-24-06 – 7-19-06	W9 or 50	97035 ($14.59 x 16 units)	1, 4, 5	$233.44
5-24-06 – 7-19-06	W9 or 50	97110 ($33.46 x 43 units)	1, 4, 5	$1,438.78
6-26-06, 9-6-06	W9 or 50	99080-73	1, 7	$15.00
9-6-06	W9 or 50	99455-VR	1, 8	$50.00
Total Due:				$3010.27

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.

Per Rule 133.307 (d)(1) date of service 4-3-06 and 4-4-06 were not timely filed and are ineligible for review. The statement "Reimbursement for procedure was withheld due to previous submisision," was printed on some of the EOB's. The Division is uncertain what this statement means because there is no indication from either party that these services were reimbursed.

1. These services were denied by the Respondent with reason code "W9-Unnecessary med treatment based on peer review. Peer review obtained by the carrier ind treatment to be medically unreasonable and/or unnecessary and documented srvc does not meet fee guide contained W/I Appli AMA CPT/HCPCS Guide." or "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer-Unnecessary treatment (without peer review)."

2. Per Rules 134.600 (h) and 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 4-14-06 for 10 sessions of Individual Counseling from 4-11-06 through 7-11-06. The Respondent denied these sessions for unnecessary medical treatment. Per rules 133.301 (a) and 134.600 (c)(1)(B) the Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization. Reimbursement is recommended.

3. Per Rule 134. 600(h)(11) the Requestor provided a copy of a preauthorization letter dated 4-24-06 for the purchase of a "Right Medical Offloader Brace." Per Rule 134.202 (c)(6) "for products and services for which CMS or the Division does not establish a relative value unit and/or a payment amount the Respondent shall assign a relative value, which may be based on nationally recognized published relative value studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments." Reimbursement is recommended per Rule 134.202 (c)(6).

4. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 5-24-06 for twelve sessions of Physical Therapy. The Requestor also provided a copy of a decision by an Independent Review Organization (M2-06-1185-01) dated 5-9-06 which authorized seventeen sessions of Physical Therapy. The Respondent denied these sessions for unnecessary medical treatment. Per Rule 134.600 (c)(1)(B) the Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization. Reimbursement is recommended.

5. Per review of Box 32 on CMS-1500, zip code 78229 is located in Bexar County.

6. 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."

7. The Respondent denied this service as "unnecessary medical treatment," however, the DWC-73 is a required report and cannot be denied for medical necessity. Medical Dispute Resolution has jurisdiction in this matter. Reimbursement is recommended per Rule 129.5(i).

8. CPT code 99455-VR was denied as "unnecessary medical treatment." CPT code 99455-VR is a DWC required report and not subject to an IRO review, therefore was denied inappropriately. The billing of CPT code 99455-VR is in compliance with Rule 134.202(e)(6)(F). Reimbursement is recommended.

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rules 133.301(a) and 133.307(e)(3)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §129.5(i), §134.1, §134.202, §134.600

PART VII: DIVISION DECISION AND/OR 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 $3010.27 plus DME amount per Rule 134.202 (c)(6) plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

7-9-07

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.