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:	MFDR Tracking #: M4-07-4929-01
Dipti Patel, D.C. 6660 Airline Drive Houston, Texas 77076	DWC Claim #: Injured Employee:
Respondent Name and Box #:	Date of Injury:
FORT BEND I. S. D. REP BOX #: 29	Employer Name: FORT BEND I. S. D. Insurance Carrier #: 57342991

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Our facility had pre-authorization for these services. In addition, we have provided proof that the carrier recvd these medical bills."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. Preauthorization Approval Letter dated 11/27/06

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the DWC-60.

Principle Documentation:

1. N/A

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
11/28/06 11/29/06 12/01/06	No EOBs/No EOBs	97545-WH x 1 Unit x 3 Days 97546-WH x 5 Hours x 3 Days	1 2	$307.20 $768.00
Total Due:				$1,075.20

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.

Preauthorization approval #79536799-1 was given by the Respondent on 11/27/06 for a Work Hardening Program x ten (10) sessions to be completed by 01/12/07.

Rule 134.600(c)(i)(B), states, "…The carrier is liable for all reasonable and necessary medical costs relating to the health care…listed in subsection (p) or (q) of this section only when the following situations occur…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(e)(5)(A)(ii), A Non-CARF accredited program shall be reimbursed at 80% of the MAR. Per Rule 134.202(e)(5)(c)(i), the first two hours of each session shall be billed and reimbursed as one unit. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00 per hour."

The Requestor did submit convincing evidence of carrier receipt for "Request for EOBs" in accordance with 133.307(e)(2)(B).

1. This dispute is related to CPT code 97545-WH x 1 Unit for dates of service 11/28/06, 11/29/06 and 12/01/06. Neither the Requestor nor the Respondent provided EOBs for the disputed dates of service, therefore, the disputed services will be reviewed according to the 2002 Medical Fee Guideline. Reimbursement is recommended.

    - CPT code 97545 WH x 1 Unit = $102.40 x 3 Days = $307.20

2. This dispute is related to CPT code 97546-WH x 5 Hours for dates of service 11/28/06, 11/29/06 and 12/01/06. Neither the Requestor nor the Respondent provided EOBs for the disputed dates of service, therefore, the disputed services will be reviewed according to the 2002 Medical Fee Guideline. Reimbursement is recommended.

    - CPT code 97546 WH x 1 Hour = $51.20 x 5 hours = $256.00 x 3 Days = $768.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §133.307, §134.600, 2002 Medical Fee Guideline

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 **$1,075.20** plus accrued interest, due within 30 days of receipt of this Order.

Ordered by:

05/24/07

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.