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 South McColl Rd. Edinburg, Texas 78539-9168	MFDR Tracking #: M4-07-4978-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL BOX 19	Date of Injury: Employer Name: CITY OF EDINBURG Insurance Carrier #: T120500113017

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The therapy was pre-authorized treatment…Please review the fax and the doctor's written request which clearly indicates the procedure codes that were requested…."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Preauthorization Letters

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "This case involves DOS 4-20-06 through 8-11-06…Carrier denied payment because of improper unbundling and documentation that failed to justify the billed services…."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
4-20-06 – 4-27-06 5-12-06 – 5-16-06	R95, 50, B15, W4	97033 ($23.93 x 5 units)	1, 4, 5	$119.65
4-28-06 – 5-03-06	R95, B15, W1, W4	97033 ($23.93 x 3 units)	2, 4, 5	$71.79
4-25-06 – 5-16-06	R80, B15, W1, W4	97110-59 ($33.46 x 30 units)	2, 4, 5	$1,003.80
8-7-06, 8-11-06	505, 192, W1	97035 ($14.59 x 2 units)	3, 4	$29.18
8-11-06	505, 192, W1	97124	3, 4	$26.55
Total Due:				$1,250.97

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 "R95-Proc. Billing Restricted/Medicare LCD," "50-Not-covered: Not deemed a 'medical necessity'," "B15-Adj procedure/service is not paid separately," and "W-4-No additional reimbursement allowed after review of appeal/reconsideration."

2. These services were denied by the Respondent with reason code "505-Maximum units exceeded, payment adjusted," "192-Exceeds expected treatment frequency," and "W1-Workers Compensation State Fee Schedule Adjustment."

3. Review of the Box 32 on CMS-1500, revealed zip code 78539 is located in Hidalgo County.

4. Per Rules 134.600 (h) and 134.600 (c)(1)(B), the Requestor provided copies of preauthorization letters dated 4-19-06 (#79530708-1) and 7-20-06 (#79533229-1) for a total of 21 sessions of Physical Therapy. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "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 under Chapter 134 of this title."

5. Per Rule 134.202(b) this procedure is not considered to be a component procedure of any other service which was billed on this date of service.

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rule 133.301(a) and Rule 134.600 (c)(1)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.301, §134.1, §134.202

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 $1,250.97 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.