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:	MFDR Tracking #: M4-07-5409-01
Frank Gonzales, D.C. P O BOX 3228 Odessa, Texas 79760-3228	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
Gray Insurance Company Inc. Rep Box # 19	Employer Name: Abbott Building Company Inc.
	Insurance Carrier #: 2005000850

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier was in violation of the laws and rules as stated in Rule 133.301(a) where it clearly states the insurance company shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or services for which the health care provider has obtained pre-authorization under Chapter 134 of this title (relating to Benefits – Guidelines for Medical Services, Charges, and Payments)."

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

Respondent's Position Summary: "This case should be dismissed, in accordance with 28 TAC §§ 133.305(b) and 133.308(e)(3)(G). As noted by the original DWC Form-62 and the attached Amended DWC Form-62, there are medical necessity disputes that have not been resolved. Those disputes are pending before TDI-HWCN…The attached Amended DWC-60 indicates the Carrier's position on any other of the services. In particular, the Requestor received preauthorization to perform work hardening as that service is defined by the MFG. The Carrier expected the Requestor to provide work hardening services that complied with CARF program standards. Records reveal the services did not comply with CARF program standards and did not constitute a legitimate work hardening program."

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
08-23-06	W1 & 50	97035 (1 unit @ $14.59)	1, 2(a)(b), 3, 4, 5	$14.59
10-03-06	W1, 50 & 62	97035 (1 unit @ $14.59)	1, 2(a)(b), 3, 4, 5	$14.59
08-23-06	W1 & 50	97110 (1 unit @ $33.46 x 3 units)	1, 2(a)(b), 3, 4, 5	$100.38
10-03-06	W1, 50 & 62	97110 (1 unit @ $33.46 x 3 units)	1, 2(a)(b), 3, 4, 5	$100.38
08-23-06	W1 & 50	G0283 (1 unit @ $13.58)	1, 2(a)(b), 3, 4, 5	$13.58

10-03-06	W1, 50 & 62	G0283 (1 unit @ $13.58)	1, 2(a)(b), 3, 4, 5	$13.58
10-17-06 to 10-30-06	W1/62/150/B12 *** see note below	97545-WH ($51.20 x 2 units X 10 DOS) 97546-WH ($51.20 x 5 hours x 1 DOS) 97546-WH ($51.20 x 6 hours x 7 DOS) 97546-WH ($51.20 x 2 hours x 2 DOS)	1, 2(a-c), 3, 5 & 6	$1,024.00 $256.00 $2,150.40 $204.80
10-31-06	W1/62 *** see note below	97545-WH ($51.20 x 2 units x 1 DOS) 97546-WH ($51.20 x 6 hours x 1 DOS)	1, 2(a-c), 3, 5 & 6	$102.40 $307.20
11-01-06	W1/62 *** see note below	97545-WH ($51.20 x 2 units x 1 DOS)	1, 2(a-c), 3, 5 & 6	$102.40
12-06-06 to 12-15-06	W1/62/150/B12 *** see note below	97545-WH ($51.20 x 2 units x 8 DOS) 97546-WH ($51.20 x 5 hours x 1 DOS) 97546-WH ($51.20 x 6 hours x 4 DOS) 97546-WH ($51.20 x 2 hours x 3 DOS)	1, 2(a-c), 3, 5 & 6	$819.20 $256.00 $1,228.80 $307.20
Total Due:				$7,015.50

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 submitted an updated Table of Disputed services on 06-06-07 which will be used for the review by MFDR. The Requestor on 06-06-07 also withdrew dates of service 12-18-06, 12-19-06, 12-20-06 and 12-21-06; therefore, these dates will not be a part of the review.

1. These services were denied by the Respondent with denial reason codes:
   - W1/50 - Not medically necessary per peer reviews, including 12/11/06. Treatment is not reasonable and necessary as per attached peer review of 12/28/05.
   - W1/62 - Not within preauthorized services.
   - W1/62/150/B12 - Treatment provided does not correspond to the requested and approved care as represented by the provider (28 TexReg 9892); the services actually provided do not comply with the requirements for work hardening under 28 TAC §134.202).
   - *** - Service denied as "treatment is not reasonable and necessary as per attached peer review 9/28/06.

2. (a) The Requestor obtained preauthorization (pre-authorization # 600325) dated 07-14-06 authorizing outpatient physical therapy to the right shoulder three (3) times a week for four (4) weeks for twelve (12) sessions to consist of interferential stimulation, ultrasound and therapeutic exercises. The carrier also authorized on 09-06-06 outpatient chiropractic therapy to the right shoulder three (3) times a week for four (4) weeks for twelve (12) sessions of therapeutic exercises (pre-authorization # 605263). On 10-17-06 the carrier authorized work hardening five (5) times a week two (2) weeks or ten (10) sessions for the right shoulder (pre-authorization # 609334). On 12-04-06 the carrier authorized outpatient work hardening as related to the right shoulder five (5) days a week for two (2) more weeks for ten (10) sessions (pre-authorization # 613721).

   (b) 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."

   (c) Per Rule 133.307(g)(3)(A-F) review of documentation submitted by the Requestor supports the services billed.

3. Per review of Box 32 on CMS-1500 zip code 79703 is located in Midland County.

4. Reimbursement is recommended per Rule 134.202(c)(1) in the following amounts:

   CPT code 97035 - $29.18 ($14.59 x 2)
   CPT code 97110 - $200.76 ($100.38 x 2)
   CPT code G0283 - $27.16 ($13.58 x 2)

5. In their position statement the Respondent stated in part "This case should be dismissed, in accordance with 28 TAC §§ 133.305(b) and 133.308(e)(3)(G). As noted by the original DWC Form-62 and the attached Amended DWC Form-62, there are medical necessity disputes that have not been resolved. Those disputes are pending before TDI-HWCN…" The Requestor submitted information regarding the services in dispute pending before TDI-HWCN. Those services are for different dates of service than those listed by the Requestor on the Table of Disputed Services and for services denied for medical necessity which require a retrospective review by an IRO per Rule 133.308. The services requested for review in this dispute pertain to preauthorized services denied for medical necessity and preauthorization or a medical fee dispute per Rule 133.307.

6. Reimbursement is recommended per Rule 134.202(e)(5)(A)(ii) and 134.202(e)(5)(C)(i)(ii) in the following amounts:

   CPT code 97545-WH $2,048.00 (1 unit @ $51.20 x 40 hours)
   CPT code 97546-WH $4,710.40 (1 unit @ $51.20 x 92 hours)

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600 as referenced in number two (2) above and for denying with an improper denial reason code.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §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 $7,015.50 plus accrued interest, due within 30 days of receipt of this Order

DECISION:

		06-21-07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

ORDER:

		06-21-07
Authorized Signature	Manager, Medical Fee Dispute Resolution	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.