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: Southeast Health Services P. O. Box 453062 Garland, Texas 75045	MFDR Tracking #: M4-07-5678-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Continental Casualty Company Box 42	Date of Injury: Employer Name: Dallas ISD Insurance Carrier #: 2005036153

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "The claim was denied as "not preauthorized," however, please note that this claim was preauthorized under Approval # AP 129405 and an extension of days was given by Maria at Argus through May 1, 2006."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "For May 1, 2007 no allowance is recommended. The April 30, 2006 authorization was for four weeks and this ended on April 30, 2006."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
5-1-06	62A	97110-59 ($34.46 x 4 units)	1, 2, 6, 7	$137.84< MAR
5-1-06	62A	97032	1, 2, 6, 7	$19.58< MAR
5-1-06	62A	97016	1, 2, 6, 7	$17.34< MAR
5-1-06	62A	97035	1, 2, 6, 7	$14.86< MAR
5-3-06	62A	99080-73	1, 3	$15.00
5-18-06	W9	99080-73	4	$15.00
7-27-06	97H	93799	5	$0.00
Total Due:				$219.62

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 4-27-06 was not timely filed and is ineligible for review.

1. These services were denied by the Respondent with reason code "62A-Payment denied /reduced for absence of, or exceeded, pre-certification/authorization."

2. Requestor provided a copy of Preauthorization Report dated 3-30-06 (#AP129405) for Physical Therapy three times a week for four weeks. The Extension on 5-1-06 states, "Preauthorization extension granted until 5-1-06." Per Rule 134.600 these services require preauthorization. Reimbursement per 134.202(c)(1) is recommended

3. The DWC-73 Report does not require Preauthorization per Rule 134.600. Recommend reimbursement per 129.5.

4. The Respondent denied this service as "W9-unnecessary medical treatment based on peer review." The DWC-73 is a required report per Rule 129.5 and cannot be denied for medical necessity. Medical Dispute Resolution has jurisdiction in this matter. Recommend reimbursement per 129.5(i).

5. These services were denied by the Respondent with reason code "97H-Payment is included in the allowance for another service/procedure billed on the same date." Per Rule 134.202(e)(4) this service, "Unlisted cardiovascular service or procedure," is part of the FCE which was billed on the same date of service. No reimbursement recommended.

6. Per review of Box 32 on CMS-1500, zip code 75217 is located in Dallas County.

7. 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."

A Legal and Compliance referral has been made for inappropriate denial of Required Report (99080-73 on 5-18-06) per Rule 129.5(i).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §129.5, §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 $219.62 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

	Donna Auby	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.