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: Alta Vista Healthcare 5445 La Sierra Dr Ste 204 Dallas, TX 75231-3444	MFDR Tracking #: M4-07-5690-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO BOX 19	Date of Injury: Employer Name: BURLINGTON COAT FACTORY Insurance Carrier #: 3471095437

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "An evaluation of this nature is essential for identifying safe functional tolerances, physical deficits, and treatment planning. These evaluations are lengthy, time-intensive, and face-to-face assessment…"

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

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
12-21-06	18-459	97001	1, 2	$0.00
Total Due:				$0.00

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 "18-459. This provider has already billed and been reimbursed for an initial office visit."

2. Per Rule 134.202(b) CPT code 97001 is described as, "The health care provider examines the patient/client. This includes taking a comprehensive history, systems review, and tests and measures. Tests and measures may include but are not limited to tests of range of motion, motor function, muscle performance, joint integrity, neuromuscular status, and review of orthotic or prosthetic devices. The PT formulates an assessment, prognosis, and notes an anticipated intervention." This is an INITIAL Physical Therapy Evaluation. It is only allowed once. The Respondent reimbursed the Requestor for this service on 6-6-06. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §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 not entitled to reimbursement for the services involved in this dispute.

DECISION:

7-13-07

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.