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: Kimberly Driggers, D.C. 1042 Central Parkway South San Antonio, Texas 78232	MFDR Tracking #: M4-07-5967-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Company Box # 54	Date of Injury: Employer Name: John Stuart Sitework LTD Insurance Carrier #: 99G0000442657

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "As reflected in the enclosed documents, including the Request for Reconsideration, provider duly obtained preauthorization for the 12 visits and did not exceed this number of visits, the PT codes or the dates for providing the services. Please order reimbursement to our office for the denied billings as reflected on the DWC060 [sic] as well as statutory interest.

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: States in part "According to the preauthorization letter provided it states, "the bills for services are processed in accordance with DWC Rule 134.202 Medical Fee Guideline, DWC Rule 134.202 Ambulatory Surgical Center Fee Guideline, DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline and 413.011 of the Texas workers' Compensation Act;…(Exhibit 2) Further, per verbal notification given 11/20/06; the session/visit is limited to no more than an hour, no more than 4 CPT codes, and no more than 45 minutes of cumulative timed codes…"

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
11-21-06 to 12-18-06	62/W4/891/930	97140-59 (1 unit @ $31.15 x 12 units)	1 - 4	$373.80
11-21-06 to 12-18-06	62/W4/891/930	97110 (1 unit @ $33.46 x 51 units)	1 - 4	$1,706.46
11-21-06 to 12-18-06	62/W4/891/930	97032 (1 unit @ $18.94 x 12 units)	1 - 4	$227.28
Total Due:				$2,307.54

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 was contacted and verified that the Respondent has not made any payment.

1. These services were denied by the Respondent with reason codes:
   - 62 - Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - W4 - No additional reimbursement allowed after review of appeal/reconsideration.
   - 891 - The insurance company is reducing or denying payment after reconsideration.
   - 930 - Pre-authorization required, reimbursement denied.

2. Preauthorization was obtained by the Requestor prior to the services being rendered in accordance with Rule 134.600. A copy of a preauthorization dated 11-20-06 (reference number 1825335) was submitted for review by the Requestor which authorized CPT codes 97110, 97032 and 97140 for 12 visits with a start date of 11-20-06 and an end date of 12-29-06. The Respondent has denied the services with an improper denial reason.

3. Per review of Box 32 on CMS-1500 zip code 78238 is located in Bexar County.

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

   CPT code 97140-59 - $373.80
   CPT code 97110 - $1,706.46
   CPT code 97032 - $227.28

A Legal and Compliance referral is made due to the Respondent denying the services with an improper denial code.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §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 $2,307.54 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		06-25-07
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.