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: Southeast Health Services P.O. Box 170336 Dallas, Tx. 75217	MFDR Tracking #: M4-07-6678-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INDEMNITY INS. CO. OF N. AMERICA REP. BOX # 15	Date of Injury: Employer Name: Insurance Carrier #: 012006038421WC01

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "This treatment was denied as "not preauthorized," however, according to rule 134.600 (p) (5) C), the first six visits of occupational therapy do not require preauthorization. Please reprocess this date of service for payment based on this information."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Position summary not submitted to MDR.

Principle Documentation:

1. Response to DWC 60
2. EOBs
3. Payment Screens

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
9-05-06	F & W4	97032 97012 97035	1,2 &3 1,2 &3 1,2 &3	$20.50 $18.99 $15.58
Total Due:				$55.07

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, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "F" (Fee Guideline MAR Reduction), "W4"(No add'l. reimbursement allowed after review of appeal/reconsideration), and (treatment denied as "not preauthorized").

2. Per Rule 134.600 (p) (5) (C), the first six visits of physical therapy do not require pre-authorization. The disputed DOS was performed within the 2 week timeframe. The Respondent has paid for other therapy modalities for this same DOS, therefore per Rule 134.202 (b) and (c) (1) payment is recommended. The Respondent is claiming a payment was made in the amount of $46.41; however this appears to be for different CPT codes from the codes in dispute. The Respondent is claiming a payment made in the amount of $55.07; however this appears to be for a different date of service from that in dispute.

    - 97032: $16.40 x 125%=$20.50
    - 97012: $15.19 x 125%=$18.99
    - 97035: $12.46 x 125%=$15.58

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

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §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 $55.07 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / 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.