



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address: Texas Health 5445 La Sierra Drive # 204 Dallas, Texas 75231	MFDR Tracking #: M5-07-0392-01
	DWC Claim #:
	Injured Employee:
Respondent Name: Great American Alliance Insurance  Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "In summary, it is our position that Great American Alliance has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to ... "

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: "Carrier challenges whether the charges are consistent with applicable fee guidelines. 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/or Description	Part V Reference	Amount Due
12-28-05	50, 283, 277, 18	90806	1-4	\$119.75
01-18-06	50 and 283	90806-59	2, 3, 5 and 6	\$119.75
12-28-05	50, 283, 277, 18	90901	2, 3, 7 and 8	\$47.39
01-18-06	50 and 283	90901	2, 3, 9 and 10	\$47.39
<b>Total Due:</b>				<b>\$334.28</b>

### 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.

On 03-29-07 the Requestor withdrew CPT code 90880 billed for date of service 01-18-06 from the dispute, therefore, this service will not be a part of the review by Medical Dispute Resolution.

1. This dispute relates to CPT code 90806 with denial reason code “50” – (these are non-covered services because this is not deemed a ‘medical necessity’ by the payer), denial reason code “283” – (based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary), denial reason code “277” – (these services/charges have been previously reviewed and allowance recommended on another analysis. Returned as a duplicate bill) and denial reason code “18” – (duplicate claim/service).
2. The Requestor obtained preauthorization (preauthorization number 192932) prior to the service(s) being rendered.
3. The Respondent is in violation of Rule 133.301(a) which states “the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title”.
4. Per CMS-1500, the zip code 75231 is located in Dallas County. The MFG MAR for CPT code 90806 in Dallas County is \$126.75 per Rule 134.202(c)(1). Per the *Table of Disputed Services*, the Requestor is seeking medical dispute resolution for \$119.75, this amount is recommended.
5. This dispute relates to CPT code 90806-59 with denial reason code “50” – (these are non-covered services because this is not deemed a ‘medical necessity’ by the payer) and denial reason code “283” – (based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary).
6. Per CMS-1500, the zip code 75231 is located in Dallas County. The MFG MAR for CPT code 90806-59 in Dallas County is \$126.14 per Rule 134.202(c)(1). Per the *Table of Disputed Services*, the Requestor is seeking medical dispute resolution for \$119.75, this amount is recommended.
7. This dispute relates to CPT code 90901 with denial reason code “50” – (these are non-covered services because this is not deemed a ‘medical necessity’ by the payer), denial reason code “283” – (based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary), denial reason code “277” – (these services/charges have been previously reviewed and allowance recommended on another analysis. Returned as a duplicate bill) and denial reason code “18” – (duplicate claim/service).
8. Per CMS-1500, the zip code 75231 is located in Dallas County. The MFG MAR for CPT code 90901 in Dallas County is \$53.35 per Rule 134.202(c)(1). Per the *Table of Disputed Services*, the Requestor is seeking medical dispute resolution for \$47.39, this amount is recommended.
9. This dispute relates to CPT code 90901 with denial reason code “50” – (these are non-covered services because this is not deemed a ‘medical necessity’ by the payer) and denial reason code “283” – (based on a peer review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary).
10. Per CMS-1500, the zip code 75231 is located in Dallas County. The MFG MAR for CPT code 90901 in Dallas County is \$53.30 per Rule 134.202(c)(1). Per the *Table of Disputed Services*, the Requestor is seeking medical dispute resolution for \$47.39, this amount is recommended.

A Legal and Compliance referral will be made due to the Respondent being in violation of Rule 133.301(a).

## **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d)  
28 Texas Administrative Code Sec. §134.1, §134.202 and 133.301

**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 \$334.28 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order by:

04-25-07

Authorized Signature

Medical Fee Dispute Resolution Officer

Date of Decision and Order

**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.**