



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 NECESSITY AND FEE DISPUTE RESOLUTION
FINDINGS AND DECISION**

PART I: GENERAL INFORMATION

Requestor's Name and Address: ERGOMONIC REHABILITATION OF HOUSTON 283 LOCKHAVEN DRIVE SUITE 315 HOUSTON, TX 77073	MFDR Tracking #: M5-08-0104-01
	Previous Tracking #: M4-05-9018-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: HARRIS COUNTY Box 21	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Please review the paperwork and rule in our favor in this case as this insurance carrier did not comply with the TWCC rules in their use of exception codes either time our charges were submitted."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$2,755.62
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

No Position Summary was received from the Respondent.

PART IV: SUMMARY OF FINDINGS – MEDICAL NECESSITY ISSUES

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
12-7-04 – 2-11-05	97110	F72, W4F, W4E	1, 2, 3	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

For date of service 1-19-05 Texas Labor Code 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 codes “F72-TWCC Code F – Fee Guideline MAR Reduction. Treatment has exceeded Medicare Guidelines for length of treatment session(s),” “W4F-No additional reimbursement allowed after review of appeal/reconsideration. Medical records do not justify medical necessity of exceeding 45 mins of physical therapy,” and “W4E - No additional reimbursement allowed after review of appeal/reconsideration. Duplicate Appeal. An appeal of the original audit was previously performed for these services.”
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. This denial reason is not supported.
3. The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement is recommended.
4. CPT code 97002-25 on 1-19-05 was denied by the Respondent with reason codes “F96-TWCC Code F – Fee Guideline MAR Reduction. Provider billed for new patient services when records indicate that the patient was established prior to these services,” and “W4-No additional reimbursement allowed after review of appeal/reconsideration.” Per 134.202(b) this service is described as, “The health care provider re-examines the patient/client to obtain objective measures of progress toward stated goals.” The Requestor did not provide documentation to enable the Division to confirm these services per Rule 133.307(g)(3)(A-F). No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
 28 Texas Administrative Code Sections 133.307 eff. 1-1-03, 133.308 eff. 1-2-03, 134.1 eff. 5-16-02, 134.202
 Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the IRO fee in this dispute.

DECISION:

Donna D. Auby
 Medical Fee Dispute Resolution Officer

10-29-08

Authorized Signature

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.