Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Rehab 2112 P. O. Box 671342 Dallas, TX 75267-1342	MFDR Tracking #: M4-05-0846-01 DWC Claim #: Injured Employee:
Respondent Name: FINANCIAL INSURANCE CO OF AMER Box: #42	Date of Injury: Employer Name: SERVICE PROFESSIONALS OF TEXAS Insurance Carrier #: 20010X1

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "The carrier processed the FCE's incorrectly…The work hardening program is exempt from pre-authorization due to our CARF accreditation. See copy of CARF letter and TWCC exemption letter."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No response was received from the Respondent.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
10-03-03	F	16 units 97750-FC - $587.00<MAR minus $147.76 (Respondent paid)	1, 2	$439.24
10-27-03	F	8 units 97750-FC - $294.00<MAR minus $146.76 (Respondent paid)	1, 3	$147.24
10-08-03	No EOB (Carrier used wrong date on EOB)	97546-WH-CA - $320.00 MAR minus $75.78 (Respondent paid)	1, 6	$244.22
10-09-03 – 11-19-03	A, 855-024	97545-WH-CA ($128.00 x 8 days)	1, 4, 5	$1,024.00
10-09-03 – 11-19-03	A, 855-024	97546-WH-CA - $3,008.00 MAR minus $64.00 (Respondent paid)	1, 4, 5	$2,624.00
Total Due:				$4,478.70

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. Per CMS-1500, the zip code 77057 is located in HarrisCounty. The MFG MAR for CPT code 97750-FC in Harris County is $36.94 per unit. The Requestor is asking for less than this amount. Recommend reimbursement per Rule 134.202(d)(2) of the amount the Requestor is seeking. ($439.24)

2. These services were denied by the Respondent with reason code "F-Fee Guideline MAR reduction." The Respondent did not pay per Rule 134.202(d)(2) and gave no valid reason for not doing so. The Requestor has billed $587.00. The Respondent has reimbursed $147.76. Recommend additional reimbursement per 134.202(d)(2) of $439.24.

3. These services were denied by the Respondent with reason code "F-Fee Guideline MAR reduction." The Respondent did not pay per Rule 134.202(d)(2) and gave no valid reason for not doing so. The Requestor has billed $294.00. The Respondent has reimbursed $147.76. Recommend additional reimbursement per 134.202(d)(2) of $147.24.

4. These services were denied by the Respondent with reason code "A - Preauthorization required but not requested," and "855-024 - Service is denied for lack of proof of pre-authorization." Per Rule 134.600(h)(9) CARF accredited facilities do not require preauthorization. The facility sent proof of CARF accreditation.

5. Per Rule 134.600(h)(9) work hardening services provided in a facility that has not been approved for exemption require preauthorization. The facility sent proof of CARF accreditation and DWC's Preauthorization Exemption. Per Rule 134.202(e)(5)(C)(ii) reimbursement shall be $64.00 per hour for CARF accredited programs. Recommend additional reimbursement of $3,648.00. Referral to Legal and Compliance for inappropriate denial of services.

6. Neither the Respondent nor the Requestor provided EOB's. The Requestor submitted convincing evidence of carrier receipt for "Request for Reconsideration EOB's" in accordance with 133.307(e)(2)(B). There was convincing evidence of insurance carrier receipt of request for EOB per 133.307(g)(3)(a). The MAR is $320.00 per Rule 134.202(e)(5)(C)(ii). The Respondent has reimbursed $75.78. Recommend additional reimbursement of $244.22.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.301, §133.307, §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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $4,478.70 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

	Donna D. Auby	4-27-07
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.