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: Dr. Suhail Al-Sahli 1210 Nasa Rd. #1 Houston, TX 77058	MFDR Tracking #: M4-05-1628-01 DWC Claim #: Injured Employee:
Respondent Name: Universal Underwriters Insurance Co. Box #: 10	Date of Injury: Employer Name: ASBURY AUTOMOTIVE GROUP LLC Insurance Carrier #: 2330041457

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We have appealed to collect these charges from the insurance carrier, but the carrier has failed to provide us with proper explanation for not paying for these services."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Carrier did not submit a Position Summary to MFDR.

Principle Documentation:

1. EOB
2. CMS 1500

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
09/20/04 – 09/24/04	N / No EOB	97545-WH-CA	1	$640.00
09/20/04 – 09/24/04	N / No EOB	94546-WH-CA	2	$1,600.00
Total Due:				$2,240.00

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. CPT code 97545-WH-CA billed for dates of service 09/20/04 – 09/24/04 were denied by carrier with "N" (Not documented). Per Rule 133.307, the Requestor submitted daily Work hardening notes and CMS 1500s to prove that services were rendered. Per Rule 134.600(5) (C) (ii), a CARF accredited program shall be reimbursed at $64.00 per hour. Per Rule 134.2020(5) (c) (i), the first two hours of each session shall be billed and reimbursed as one unit. Reimbursement is

recommended in the amount of **$640.00 ($64.00 X 100% = $64.00 (MAR) X 2 (1Unit) = $128.00 X 5 (DOS).**

2. CPT code 97546-WH-CA billed for dates of service 09/20/04 – 09/24/04 were denied by carrier with "N" (Not documented). Per Rule 133.307, the Requestor submitted daily Work hardening notes and CMS 1500s to prove that services were rendered. Per Rule 134.600(5)(C) (ii), a CARF accredited program shall be reimbursed at $64.00 per hour. Therefore, reimbursement is recommended in the amount of $**1,600.00 ($64.00 X 100% = $64.00 (MAR) X 5 (Units) $320.00 X 5 (DOS).**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §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 $2,240.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision & Order:

04/13/07

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.