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, Texas 75267-1342	MFDR Tracking #: M4-05-1915-01
	DWC Claim #:
	Injured Employee:
Respondent Name: ACE American Insurance Company Box #: 15	Date of Injury:
	Employer Name: 7 Eleven Inc.
	Insurance Carrier #: A46460852000010164

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Pre-auth is not required for WH programs that are CARF accredited and the programs were initiated on or after 3/15/04. This program started on 04/26/04, therefore preauth is exempt. Carrier did not process WH charges according to the TWCC Guidelines."

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: The Respondent did not submit a position summary to MDR

Principle Documentation: No response from the Respondent to MDR

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
04-30-04 to 05-11-04	A	97545-WH-CA ($128.00 X 7 DOS)	1 - 3	$896.00
04-30-04 to 05-04-04 and 05-06-04 to 05-10-04	A	97546-WH-CA ($192.00 X 5 DOS)	1 - 3	$960.00
05-05-04	F	97546-WH-CA ($192.00 minus $64.00)	4 & 5	$128.00
05-07-04 and 05-11-04	A	97546-WH-CA ($256.00 X 2 DOS)	1 - 3	$512.00
05-07-04	A	97546-WH-CA-59-52	1 - 3	$32.00
05-10-04 and 05-11-04	A	97546-WH-CA-59-52 ($16.00 X 2 DOS)	1 - 3	$32.00
Total Due:				$2,560.00

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. The service(s) was denied by the Respondent with denial reason "A" (preauthorization required but not requested).
2. The Requestor was CARF accredited, therefore, no preauthorization was required. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR.
3. Reimbursement per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C)(ii) is recommended as listed above.
4. The service was denied by the Respondent with denial reason "F" (Fee Guideline MAR reduction). The Respondent made a partial payment of $64.00.
5. Additional reimbursement is recommended per Rule 134.202(e)(5)(A)(i) in the amount listed above.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

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 $2,560.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order by:

04-06-07

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.