**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:<br><br>Rehab 2112<br>P. O. Box 671342<br>Dallas, TX 75267-1342 | MFDR Tracking #: M4-05-3166-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name:<br><br>ACE AMERICAN INSURANCE CO<br>Box: #15 | Date of Injury:<br>Employer Name: PINKERTONS<br>Insurance Carrier #: C135C6540798 |

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

Requestor's Position Summary (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 3-29-04. Therefore preauth is exempt. Carrier did not process WH charges according to the TWCC Guidelines or our CARF accreditation.

Principle Documentation:

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

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondents's Position Summary: The Clinic (Rehab 2112) is CARF accredited. The bills were audited and payment was issued.

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 |
|---|---|---|---|---|
| 3-29-04, 3-31-04 | A/F | 97545-WH-CA ($25.60 x 2 days) | 1, 2, 3 | $51.20 |
| 3-29-04, 3-31-04 | A/F | 97546-WH-CA ($64.00 hr. x 2 units) | 1, 2, 3 | $128.00 |
| 5-14-04 | F/O | 99455-WP-V4 | 4, 5 | $71.26 |
| **Total Due:** | | | | $250.46 |

## 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. The Requestor has withdrawn DOS 4-16-04 – 5-04-04. These services will not be a part of this review.

1. These services were initially denied by the Respondent with reason code "A-This procedure/supply must be pre-authorized in accordance with TWCC Rule 134.600." The reconsideration EOB was "F-Reduction according to medical fee Guideline."

2. Per Rule 134.600 CARF accredited facilities do not require preauthorization. Reimbursement shall be $64.00 per hour. The carrier has reimbursed 80% of the MAR. Recommend additional reimbursement in the amount of $179.20.

3. A Legal and Compliance referral will be made for incorrect payment of the CARF rate for work hardening programs.

4. These services were denied by the Respondent with reason code "F-Work related/med disabil applicable established patient office visit level associated with the examination. MMI/IR Whole procedure."

5. Per Rule 134.202(e)(6)(D)(iii)(II)(b): "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas…The MAR for musculoskeletal body areas shall be as follows…If full physical evaluation, with range of motion, is performed (1) $300.00 for the first musculoskeletal body area; and, (2) $150 for each additional musculoskeletal body area." Reimbursement should be $300.00 for the Shoulder Impairment Rating Evaluation (Range of Motion exam was performed), $150.00 for the Back Impairment Evaluation and $101.74.00 for the Office Visit. The MAR for the Office Visit (CPT code 99214) for Tarrant County is $101.74. The total amount of the MAR is $551.74. The Respondent has reimbursed $451.74. Recommend additional reimbursement per Rule 134.202(d)(1) of $71.26.

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

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.301, §134.1, §134.202, §134.600

**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 $250.46 plus accrued interest, due within 30 days of receipt of this Order.

**Decision:**

| | Donna D. Auby | 4-10-07 |
|---|---|---|
| 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.**