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: Central Dallas Rehab 3523 McKinney Ave. Ste#246 Dallas, Texas 75204-1401	MFDR Tracking #: M4-05-3678-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO. REP BOX #: 19	Date of Injury: Employer Name: Robertson Electric Inc. Insurance Carrier #: 149136233

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The rationale on the Table of Dispute Services states, "Fee Dispute."

Principle Documentation:

1. DWC 60 package
2. CMS 1500
3. EOB
4. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "This is a fee dispute involving issues of causal relation. In particular, the carrier contends that the treatments underlying the charges in dispute appear to be for body parts and/or conditions not related to the compensable injury. In accordance with 28 TAC Sections 133.307(e)(2)(D), 133.308(f)(7) and/or 133.308(t), any request for resolution of a fee dispute and any request for an IRO must be held in abeyance until such liability disputes have been resolved by final decision of the TWCC. Carrier will not be liable for an IRO fee incurred as a result of any referral in violation of this rule of abeyance."

Principle Documentation:

1. 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
07/09/04	X338, Z121, Z431	97750-FC – 16 units	1	$592.80
08/04/04-08/23/04	X338, Z121, Z343	97545-WH-CA x 9 units	2	$1,152.00
08/04/04-08/23/04	X338, Z121, Z343	97546-WH-CA x 53 hrs.	3	$3,392.00
Total Due:				$5,136.80

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. This dispute is related to CPT code 97750-FC x 16 units for date of service 07/09/2004 was denied with reason codes "X338-Service rendered does not relate to an accepted compensable injury or disease." Per the Benefit Dispute

Agreement, signed by both parties on 08/10/04, "The parties agree the compensable injury on ___ includes a lumbar strain/sprain. It does not include lumbar degenerative disc or joint disease." The Requester billed with the diagnosis code 722.10 Displacement of Lumber Intervertebral Disc without Myelopathy. Therefore, per 134.202(c)(1) &134.202(e)(4) additional reimbursement is recommended in the amount of **$592.80 ($29.64 x 125%=$37.05 per unit (MAR) x 16 units (initial test) = $592.80)**.

2. This dispute is related to CPT code 97545-WH-CA x 9 units for date of service 08/04/04-08/23/04 that was denied with reason codes "X338-Service rendered does not relate to an accepted compensable injury or disease." Per the Benefit Dispute Agreement, signed by both parties on 08/10/04, "The parties agree the compensable injury on 12-10-03 includes a lumbar strain/sprain. It does not include lumbar degenerative disc or joint disease." Per Rule 134.202(e)(5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00 per hour." Per Rule 134.202(5)(c)(i), the first two hours or each session shall be billed and reimbursed as one unit; therefore, reimbursement recommended in the amount of **$1,152.00 ($64.00 per hour (MAR) x 1unit(first initial two hours) = $128.00 x 9 dos = $1,152.00)**.

3. This dispute is related to CPT code 97546-WH-CA x 53 hours for date of service 08/04/04-08/23/04 that was denied with reason codes "X338-Service rendered does not relate to an accepted compensable injury or disease." Per the Benefit Dispute Agreement, signed by both parties on 08/10/04, "The parties agree the compensable injury on 12-10-03 includes a lumbar strain/sprain. It does not include lumbar degenerative disc or joint disease." Per Rule 134.202 (e)(5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00 per hour." Therefore, reimbursement is recommended in the amount of **$3,392.00 ($64.00 per hour (MAR) x 53 hours = $3,392.00)**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307 (effective 12/31/06)
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 **$5,136.80** plus accrued interest, due within 30 days of receipt of this Order.

Ordered by:

	Marguerite Foster	05/02/07
Authorized Signature	Medical Fee Dispute Resolution Manager	Date of Order

Decision by:

		05/02/07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date of Decision

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.