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 #: M4-05-4191-01 DWC Claim #: Injured Employee:
Respondent Name: Zurich American Insurance Company Box #: 19	Date of Injury: Employer Name: Texas Stone & Tile Inc. DVR Insurance Carrier #: 6450178569

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Services not paid according to 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

Respondent's Position Summary: The Respondent did not submit a position summary

Principle Documentation: 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
06-16-04, 06-21-04, 06-25-04, 06-28-04, 07-02-04 & 07-05-04	none	97546-WH-CA ($256.00 X 6 DOS)	1 - 4	$1,536.00
06-17-04, 06-22-04 and 07-06-04	none	97546-WH-CA ($128.00 X 3 DOS)	1 - 4	$384.00
06-17-04	none	97545-WH-CA-59-52	1 - 4	$48.00
06-21-04	none	97546-WH-CA-59-52	1 - 4	$32.00
06-23-04 and 06-24-04	none	97546-WH-CA ($320.00X 2 DOS)	1 - 4	$640.00
06-25-04, 06-28-04 and 07-02-04	none	97546-WH-CA-59-52 ($64.00 X 3 DOS)	1 - 4	$192.00
06-30-04	none	97546-WH-CA	1 - 4	$192.00
06-30-04 and 07-05-04	none	97546-WH-CA-59-52 ($16.00 X 2 DOS)	1 - 4	$32.00
07-06-04	none	97546-WH-CA-59-52	1 - 4	$48.00
Total Due:				$3,104.00

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 Respondent denied the service with the explanation "the bill has been reviewed pursuant to the Rules and Regulations of the Official Medical Fee Schedule."

2. The Respondent has not made any reimbursement.

3. The Requestor is CARF accredited. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR.

4. Reimbursement is recommended as listed above per Rule 134.202(e)(5)(C)(ii) which states "Reimbursement shall be $64.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

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 $3,104.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order by:

		04-04-07
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.