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 #: M4-05-4598-01 DWC Claim #: Injured Employee:
Respondent Name: City Public Service Board Box #: 47	Date of Injury: Employer Name: City Public Service Board Insurance Carrier #: WCR0020

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Units of less than one hour for work hardening 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."

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: "According to Rule 133.304(n), Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action…"

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
05-17-04, 05-18-04 05-19-04, 05-20-04 and 06-09-04	NO EOB	97546-WH-CA-59-52 ($16.00 X 5 DOS)	1 - 3	$0.00
06-08-04 & 6-10-04	NO EOB	97546-WH-CA-59-52 ($32.00 X 2 DOS)	1 - 3	$0.00
Total Due:				$0.00

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. Review of CPT code 97546-WH-CA-59-52 revealed that neither party submitted a copy of EOBs.

2. The Requestor and Respondent submitted copies of CMS 1500's (reconsideration request) for review by MDR.

3. Review of the CMS 1500's revealed that the Requestor in accordance with Rule 133.304(k)(1)(B) did not submit for reconsideration identical codes and charges as originally billed to the Respondent, therefore no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1 and §133.304

PART VII: DIVISION FINDINGS AND DECISION

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 not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

		04-09-07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date of Findings and 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.