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 #:	M4-05-6148-01 (current MDR #) M4-04-B431-01 (former MDR #)
	DWC Claim #:	
	Injured Employee:	
Respondent Name: State Office of Risk Management Box #: 45	Date of Injury:	
	Employer Name:	State Office of Risk Management
	Insurance Carrier #:	WC2232403

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Services were appropriately documented according to 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: "In response to the original dispute packet submitted by the requestor Rehab 2112 on 08/12/04 for dates of service 10/15/03 through 01/13/04, the Office did not find record of a "Request for Reconsideration" in accordance with Rule 133.304(k) for dates of service 12/04/03 through 01/13/04 excluding 12/05/03 and 01/07/04. The requestor also failed to provide convincing evidence of receipt of a request for reconsideration."

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
10-15-03, 10-20-03 & 10-27-03	N72, N75 and 0	97110	1 & 2	$0.00
10-20-03	N72, N75 and 0	G0283	1 & 2	$0.00
10-31-03 to 01-13-04 (with the exception of the dates listed below)	N75, N3, N72, N17, N11 and 01	97545-WH-CA and 97546-WH-CA	3, 4 & 6	$0.00
11-13-03	F1, N17, N3 and N72	97546-WH-CA	4 - 6	$0.00
11-21-03	F2	97750-FC (8 units)	7	$200.46
12-12-03	F2, N3 and N72	97546-WH-CA	4, 6 & 8	$0.00
12-19-03 and 01-07-04	F2	97546-WH-CA	9	$320.00
Total Due:				$520.46

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 services in dispute were provided in Bexar County, Texas.

1. The Respondent denied the services with denial codes N72/N75 (not appropriately documented) and "O" (denial after reconsideration.

2. The Requestor did not submit documentation for review, therefore, no reimbursement is recommended.

3. The Respondent denied the services with denial codes N75, N3, N72, N17 and N11 (not appropriately documented) and/or denial reason 0/01 (denial after reconsideration).

4. The Requestor submitted documentation for review by Medical Dispute Resolution. The documentation submitted did not support the services billed i.e. number of hours of service documented did not support the number of hours billed, therefore, no reimbursement is recommended.

5. The Respondent denied the service with denial code F1 (Fee Guideline MAR reduction) and N17/N3/N72 (not appropriately documented).

6. The Respondent has made a partial payment.

7. The Respondent denied the service with denial code F2 (Fee Guideline MAR reduction). The Respondent has made a partial payment. Additional reimbursement of $200.46 ($267.28 MAR minus payment of $66.82) per Rule 134.202(c)(1) is recommended.

8. The Respondent denied the service with denial code F2 (Fee Guideline MAR reduction), N3/N72 (not appropriately documented).

9. The Respondent denied the services with denial code F2 (Fee Guideline MAR reduction). The Respondent has made a partial payment. Additional reimbursement of $256.00 ($320.00 MAR minus payment of $64.00 equals $256.00 for date of service 12-19-03) and additional payment of $64.00 ($320.00 MAR minus payment of $256.00 equals $64.00 for date of service 01-07-04) for a total additional of $320.00 is recommended per Rule 134.202(e)(5)(C)(i) and (ii).

The Requestor listed dates of service 10-31-03, 11-03-03, 11-04-03, 11-05-03, 11-06-03, 11-07-03, 11-14-03 and 11-17-03 billed for CPT code 97545-WH-CA as being in dispute. The Respondent forwarded payment information (voucher number 95B05262.07) verifying payment, therefore, these services are no longer in dispute.

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 $520.46 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order

		04-30-07
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.