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: Downtown Performance Rehabilitation 3033 Fannin Houston, TX 77004	MFDR Tracking #: M4-05-6457-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Twin City Fire Insurance Rep Box # 27	Date of Injury: Employer Name: Strategic Outsourcing Inc. Insurance Carrier #: YBUC69215

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "No response to request for reconsideration from carrier…"

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: Respondent dis not submit a position summary…"

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
08/26/04	F,D	97545-WC-GP	1	$00.00
08/27/04	F	97545-WC-GP	1	$00.00
Total Due:				$00.00

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. This dispute related to CPT code 97545-WC-GP for dates of service 08/26-08/27/04 denied with "F-Payment for interdisciplinary programs not accredited by CARF shall be reduced 20% below the usual and customary reimbursement for that program" and "D-Reimbursement for unilateral or bilateral procedures is being withheld as the maximum number of occurrences for a single date of service or maximum time for the claim has been

exceeded".

The Respondent submitted a copy of the payment screens with check # 33411548 dated 03/28/2007 in the amount of $56.00 and check # 33411547 dated 03/28/2007 in the amount of $10.94 (interest) indicating additional payment had been made to the Requestor; therefore, a dispute no longer exists.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
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 not entitled to reimbursement.

Decision:

Authorized Signature	Medical Fee Dispute Resolution Officer	05/01/2007 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.