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, TX 75267-1342	MFDR Tracking #: M4-05-6963-01 DWC Claim #: Injured Employee:
Respondent Name: INDEMNITY INSURANCE CO OF NORTH AMERICA Box: #15	Date of Injury: Employer Name: WASTE MANAGEMENT INC Insurance Carrier #: 003000127393WC0

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The work hardening services that are being reduced as a fee guideline, MAR reduction are incorrect as these bills are being billed at and should be reimbursed at the MAR level."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Response to DWC 60 was received from the Respondent.

Principle Documentation:

1. Response to DWC 60
2. CMS 1500(s)
3. EOB(s)

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
8-26-04 – 10-11-04	ON	97545-WH-CA ($25.60 x 11 days)	1, 2, 3, 4, 5	$281.60
8-26-04 – 10-11-04	ON	97546-WH-CA ($64.00 hr. x 8.8 hours)	1, 2, 3, 4, 5	$563.20
Total Due:				$844.80

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. These services were reduced by the Respondent with reason code "ON-Unless otherwise noted all reductions are due to charges exceeding the Texas Official Medical and/or Pharmaceutical Fee Guidelines allowance."

2. Per Rule 134.202(e)(5)(C)(ii) reimbursement shall be $64.00 per hour for CARF accredited programs. Requestor submitted proof of CARF accreditation through April of 2006.

3. The carrier has reimbursed 80% of the MAR. Reimbursement per the CARF rate is recommended

4. Per Rule 134.600 (p)(4), Requestors who are CARF accredited do not require preauthorization for work-hardening programs.

5. A referral will be made to Legal and Compliance for this violation of Rule 134.600.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.301, §134.1, §134.202, §134.600

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 $844.80 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

Authorized Signature	Donna D. Auby Medical Fee Dispute Resolution Officer	4-27-07 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.