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: Injury One Treatment Center 5445 La Sierra Drive, Suite 204 Dallas, Texas 75231	MFDR Tracking #: M4-05-9207-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ARCH INSURANCE COMPANY REP BOX #: 19	Date of Injury: Employer Name: Infrastrux Group, Inc. Insurance Carrier #: 002053000029WC01

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Date of service was only partially paid."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: :…Carrier also paid the work hardening services at the reduced rate because Provider did not submit documentation established that it is CARF accredited…"

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
07/20/04	EOB indicates Paid	97546 WC-CA x 6 hours	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.

The Requestor submitted an updated Table of Disputed Services on 05/15/07 indicating that the only date of service remaining in dispute is 07/20/04 that was partially paid with a remaining unpaid balance of $22.40.

Per Rule 134.600(p)(4), a CARF accredited program does not require pre-authorization of services. The Requestor billed using modifier -CA indicating they are a CARF accredited facility. Per Rule 134.202 (5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00 per hour."

The Requestor submitted proof of their CARF accreditation DWC status exemption of work conditioning and work hardening from 03/15/04 thru 07/31/06.

1. This dispute is related to CPT code 97546 WH-CA x 6 hours for date of service 07/20/04. The EOB indicates the Respondent reimbursed the Requestor a total of $384.00 under check number 0038336685 on 08/04/05. Per Rule 134.202 (b) and (c)(1), the Requestor was appropriately reimbursed, therefore, no additional reimbursement is recommended.

   * CPT code 97546 WH-CA x 6 Hours = $00.00 ($64.00 x 6 hours = $384.00 - $384.00{insurance carrier paid} = $00.00)

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, §134.600

PART VII: DIVISION 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 additional reimbursement.

Decision by:

05/24/07

Authorized Signature	Medical Fee Dispute Resolution Officer	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.