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: Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, TX 75231	MFDR Tracking #: M4-05-9377-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ACE American Insurance Co Rep. Box # 15	Date of Injury: Employer Name: Commercial Metals Co Insurance Carrier #: C290C0148016

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…This was paid below MAR…"

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: "…Fee reimbursement…"

Principle Documentation:

1. Response to DWC 60
2. Updated Table of Disputed Services dated 2/27/06

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
11/23/04	F, S	97545-WH-CA	1-2	$36.00
Total Due:				$36.00

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-WH-CA and Respondent's denial of payment based upon, Initial denial – F – "Reduction according to medical fee guideline" and Recon denial – S – "Supplemental Payment".

2. The Requestor submitted an updated table on 2/27/06. Per Rule 134.202(e)(5)(A)(i), the Requestor is CARF accredited; therefore, reimbursement would be at 100% of the MAR. Additional payment in the amount of $36.00($128.00(MAR) minus Respondent payment of $92.00 = $36.00) is recommended.

A Legal & Compliance referral will be made against the Respondent since the Requestor is CARF accredited and payment was made below MAR.

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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the additional amount of $36.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision And Order:

	Scott Hansen	04/13/07
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.