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 #: M4-05-9397-01 DWC Claim #: Injured Employee:
Respondent Name: DOLGENCORP OF TEXAS INC Box: # 19	Date of Injury: Employer Name: DOLGENCORP OF TEXAS INC Insurance Carrier #: 20040010032766

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Carrier did not pay WH charges according to our CARF accreditation."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control…The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further the carrier challenges whether the charges are consistent with applicable fee guidelines."

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
10-06-04 – 11-19-04	F, 320	97545-WH-CA - MAR is $64.00, Respondent has reimbursed $102.40 for each date of service. ($25.60 x 9 days)	1, 2	$230.40
Total Due:				

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 denied by the Respondent with reason code "F-Fee Schedule MAR Reduction," and "320-Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary."

2. Per Rule 134.202(e)(5)(C)(ii) for CARF accredited facilities reimbursement shall be $64.00 per hour. The carrier has reimbursed 80% of the MAR. Recommend additional reimbursement. Requestor is CARF accredited through April of 2006.

3. A referral to Legal and Compliance for the Respondent will be made for improper payment 9er Rule 134.202(e)(5)(C)(ii) .

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

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 $230.40 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

Authorized Signature	Donna D. Auby Medical Fee Dispute Resolution Officer	4-05-07 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.