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:	MFDR Tracking #: M4-05-9872-01
Injury One Treatment Center 5445 La Sierra Dr. Ste 204 Dallas, Tx 75231-3444	DWC Claim #: Injured Employee:
Respondent Name and Box #: American Home Assurance Co. REP BOX #: 19	Date of Injury: Employer Name: Pon North America Inc. Insurance Carrier #: 149128551

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "AIG claims has reduced & denied payment for this patient's claims. Injury One Treatment Center is a CARF accredited facility and reimbursement is made at 100%. The treatments rendered were medically & reasonably necessary. I appreciate your help in resolving this matter."

Principle Documentation:

1. DWC 60 package
2. CMS 1500
3. EOB
4. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The current dispute involves payment for work hardening from 10/27/04-12/20/04. Carrier has paid all reasonable, necessary and related charges in accordance with the applicable fee guidelines."

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
10/27/04	M282	97546-WH-CA x 6 Hrs	1	$384.00
12/20/04	M282	97545-WH-CA x 1 Unit	2	$128.00
12/20/04	M282	97546-WH-CA x 6 Hrs	3	$256.00
Total Due:				$768.00

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 is related to CPT code 97546-WH-CA x 6 Units for date of service 10/27/04 that was denied initially, and upon reconsideration, "M282-Procedure reimbursable only when billed in conjunction with a primary procedure

on the same date of service." The Requestor billed CPT code 97546 and CPT code 97545 and according to the Requestor's notation in block 31 the medical bills were submitted to the carrier on the same date. The Respondent improperly denied for this date of service. Per rule 134.202(e)(5)(C)(ii) reimbursement is recommended in the amount of **$384.00** **($64.00/hour x 6 hours)**

2. This dispute is related to CPT code 97545-WH-CA x 1 Unit for date of service 12/20/04 hat was denied initially, and upon reconsideration, "M282-Procedure reimbursable only when billed in conjunction with a primary procedure on the same date of service." The Requestor billed CPT code 97546 and CPT code 97545 on the same CMS-1500 sent to the carrier on 12/27/04 as reflected block 31. The Respondent improperly denied for this date of service. Rule 134.202(e)(5)(C)(ii) reimbursement recommended in the amount of **$128.00** **($64.00/ hour x 2 hours(1unit)**

3. This dispute is related to CPT code 97546-WH-CA x 6 Hrs for date of service 12/20/04 that was denied initially, and upon reconsideration as, "M282-Procedure reimbursable only when billed in conjunction with a primary procedure on the same date of service." The Requestor billed CPT code 97546 and CPT code 97545 and according to the Requestor's notation in block 31 the medical bills were submitted to the carrier on the same date. The Respondent improperly denied for this date of service. Per rule 134.202(e)(5)(C)(ii) reimbursement is recommended in the amount of **$256.00** **($64.00/hour x 4 hours)**

4. A referral has been made to Legal and Compliance.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307 (effective 12/31/06)
28 Texas Administrative Code Sec. §134.1, §134.202, §129.5, §180.23, §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 **$768.00** plus accrued interest, due within 30 days of receipt of this Order.

Order:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		05/08 /07

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.