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 75231-3444	MFDR Tracking #: M4-05-A245-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: FEDERAL INSURANCE COMPANY REP BOX #: 17	Date of Injury: Employer Name: Smead Manufacturing Co. Insurance Carrier #: 001928001055WC01

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…Gallagher Bassett Insurance has denied this patient's claims. The original EOB was denied because the claim is controverted, when resubmitted the carrier has not responded yet. After reconsideration was submitted they have yet to neither make any payments nor provide our office with an EOR explaining their decision…Medical necessity was established and pre-auth is not required because Injury One is a CARF accredited facility. I requested EOB' from Gallagher Bassett for multiple dates of service and I was told that they had no record of the dates of service, on 6/2/05 I submitted the claims again like new claims for processing as of present the carrier has not made any payments nor sent us an EOBs. In summary, it is our position that Gallagher Bassett Ins. has established an unfair and unreasonable decision for denial of payment for the services that were rendered…"

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the Request for Medical Fee Dispute Resolution.

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
07/13/04-08/16/04 07/13/04-08/18/04	E/No EOB after CCH E/No EOB after CCH	97545WH-CA x 2 Units x 24 Days 97546WH-CA x 6 hours x 22 Days	1	$11,315.20
10/04/04	E/No EOB after CCH	90901	2	$ 47.23
10/04/04	E/No EOB after CCH	90880	3	$ 147.86
10/04/04	E/No EOB after CCH	90889	4	$ 00.00
Total Due:				$11,510.29

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.

A Benefit Review Conference was held on 04/28/04 to mediate resolution of the disputed issues. The parties were unable to reach an agreement.

A Contested Case Hearing was held on 06/29/04. It was determined by the Division that, "Claimant sustained a compensable injury, including a compensable low back injury, on ___. Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules."

On 06/29/04, the Appeals Panel did not issue a decision within the required time. The Decision of the hearing officer is final.

1. This dispute is related to CPT code 97545-WH-CA x 2 units for dates of service 07/13/04, 07/14/04, 07/15/04, 07/19/04, 07/20/04, 07/21/04, 07/22/04, 07/26/04, 07/27/04, 07/28/04, 07/29/04, 07/30/04, 08/02/04, 08/03/04, 08/04/04, 08/05/04, 08/09/04, 08/10/04, 08/11/04, 08/12/04, 08/13/04, 08/16/04, 08/17/04 and 08/18/04 and CPT code 97546-WH-CA x 6 hours for dates of service 07/13/04, 07/14/04, 07/15/04, 07/19/04, 07/20/04, 07/21/04, 07/22/04, 07/26/04, 07/27/04, 07/28/04, 07/29/04, 07/30/04, 08/02/04, 08/03/04, 08/04/04, 08/05/04, 08/09/04, 08/10/04, 08/11/04, 08/12/04, 08/13/04 and 08/16/04 denied with reason codes, "E—The claim is controverted. Injury did not occure [sic] while in the course and scope of employment the employer." Requestor is a CARF accredited facility. In addition, 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 Rule 134.202(5)(c)(i), the first two hours or each session shall be billed and reimbursed as one unit. Therefore, Per Rule 134.202 (b) and (c)(1) reimbursement in the amount of **$11,315.20 ($11,520.00 - $204.80 insurance carrier payment)**.is recommended.

2. This dispute is related to CPT code 90901 for date of service 10/04/04 denied with reason code, "E—The claim is controverted. Injury did not occure [sic] while in the course and scope of employment the employer." Per Rule 134.202(b) and (c)(1), reimbursement in the amount of **$47.23** ($37.78 x 125%) is recommended.

3. This dispute is related to CPT code 90880 for date of service 10/04/04 denied with reason code, "E—The claim is controverted. Injury did not occure [sic] while in the course and scope of employment the employer." Per Rule 134.202(b) and (c)(1), reimbursement in the amount of **$147.86** ($118.29 x 125%) is recommended.

4. This dispute is related to CPT code 90889 for date of service 10/04/04 denied with reason code, "E—The claim is controverted. Injury did not occure [sic] while in the course and scope of employment the employer." Per Rule 1334.202(b), this code is considered to be a bundled code and is not eligible for reimbursement. Therefore, reimbursement is not recommended.

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 amount of **$11,510.29** plus accrued interest, due within 30 days of receipt of this Order.

Order:

	Marguerite Foster	05/ 1 /07
Authorized Signature	Team Lead	
		05/ 1 /07
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.