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-A767-01 DWC Claim #: Injured Employee:
Respondent Name: INDEMNITY INSURANCE CO OF NORTH AMERICA Box: #15	Date of Injury: Employer Name: SWIFT TRANSPORTATION CO INC Insurance Carrier #: 002031002055WC0

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The work hardening services that are being reduced as a fee guideline, MAR reduction are incorrect as these bills are being billed at and should be reimbursed at the MAR level. Our facility is CARF accredited…."

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 (Table of Disputed Services): "Paid in accordance with fee schedule, fair and reasonable."

Principle Documentation:

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

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
3-17-05	F/S	97545-WH-CA ($25.60 x 1 day)	1,2	$25.60
3-11-05 – 3-17-05	F/S	97546-WH-CA (Billed $320.00 x 2 days, carrier reimbursed $256.00 x 2 DOS) Reimburse $64.00 x 2 DOS	1, 2	$128.00
3-17-05	F/S	97545-WH-CA (Billed $256.00, carrier reimbursed $204.80.) Recommend reimbursement of $51.20)	1, 2	$51.20
Total Due:				$204.80

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-For all reconsideration/adjustments/payments dispute requests please submit a copy of this EOR," and "S-This line was included in the reconsideration of this previously revised bill."

2. Per Rule 134.202(e)(5)(C)(ii) reimbursement shall be $64.00 per hour for CARF accredited programs. The Requestor submitted proof of CARF accreditation. The carrier has not reimbursed per the MAR. Recommend additional reimbursement.

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 $204.80 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

Authorized Signature	Donna D. Auby Medical Fee Dispute Resolution Officer	4-12-07 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.