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 #: M4-07-1348-01 DWC Claim #: Injured Employee:
Respondent Name: AMERICAN CASUALTY CO OF READIN Box: # 47	Date of Injury: Employer Name: BROOKDALE LIVING COMMUNITIES I Insurance Carrier #: 000675003762WC01

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "WH charges not paid according to TDI guidelines. We should receive $128.00 for the first 2 hours, $64.00 for each additional hour. For units of less than 1 hr shall be prorated by 15 min. increments per Rule 133.250…Pre-auth not required due 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 (Table of Disputed Services): "Resubmitted 11-14 with notation that pre-auth not required charges have been re-submitted."

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
4-18-06 – 4-26-06	M, 29	97545-WH-CA ($19.20 x 6 DOS)	1, 2, 5	$115.20
4-18-06 – 4-26-06	M, 29	97546-WH-CA	1, 2, 5	$271.20
5-2-06	A	97545-WH-CA	3, 4, 5	$128.00
5-2-06	A	97546-WH-CA	3, 4, 5	$176.00
Total Due:				$690.40

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.

The Requestor submitted a new Table of Revised Services on 4-4-07. This Table will be used for this review.

1. These services were denied by the Respondent with reason code "M-Payment recommended at fair and reasonable rate," and "29-The time limit for filing has expired."
2. Per Rule 134.202(e)(5)(c)(ii) reimbursement shall be $64.00 per hour. The carrier has not reimbursed the MAR. Recommend additional reimbursement.
3. These services were denied by the Respondent with reason code "A-Payment denied by the carrier as the service was rendered without pre-authorization."
4. Per Rule 134.600 (p)(4) preauthorization is not necessary for facilities which are CARF accredited.
5. A Legal and Compliance referral will be made for inappropriate denial of the preauthorized service per Rule 134.600 (p)(4).

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 $250.46 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Donna D. Auby	4-10-07

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.