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's Name and Address: Summit Rehab Centers 2420 E. Randol Mill Road Arlington, Texas 76011	MFDR Tracking #: M4-07-2351-01 DWC Claim #: Injured Employee:
Respondent Name: Dallas National Insurance Box #: 20	Date of Injury: Employer Name: AMS Staff Leasing NA Inc Insurance Carrier #: A28664

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Provider sent a request for reconsideration on November 7, 2006. Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule…If no reason is put in by carrier as to the denial the commission puts it as an "F". All Fee guidelines have been followed.

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorizations

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "This matter contains one point of contention regarding the fees Requestor billed for medical services it rendered to Claimant … from June 1, 2006 through August 11, 2006. With regard to this point of contention, Dallas National Insurance Company maintains that it complied with the Texas Labor Code and the Rules promulgated by the Division of Workers' Compensation. Thus, Dallas National Insurance Company maintains that it should not be responsible to reimburse Requestor."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76011 is located in Tarrant county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
06-08-06	50/880-104	97545-WC and 97546-WC (1 hour @ $28.80 x 8 hours)	1 & 2(a)(b) & 4	$230.40
07-05-06	15/855-024	97545-WH and 97546-WH (1 hour @ $51.20 x 8 hours)	1, 2(a), 3 & 5	$409.60
07-21-06	W10/855-016	97546-WH	1 & 6	$235.04
Total Due:				$875.04

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 an updated Table of Disputed Services to MFDR on 05-16-07 which is used for the review.

1. These services were denied by the Respondent with reason code "50(880-104)" (these are non-covered services because this is not deemed a 'medical necessity' by the payer/denied per insurance: unnecessary treatment), "15(855-024)" (payment adjusted because the submitted authorization is missing, invalid, or does not apply to the billed services or provider/service is denied for lack of proof of pre-authorization) or "W10/855-016" (No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. $72.16/Payment recommended at fair and reasonable rate $72.16).

2. (a) The Requestor obtained preauthorization (# 1299) preauthorizing work conditioning program/per hour for 4 weeks (20 days) covering dates of service 06/01/2006 to 07/15/2006 and preauthorization (#1984) preauthorizing work hardening program; initial 2 hrs (per hour) and work hardening; each add'l hour 4 x week for 4 weeks (20 sessions) covering dates of service 07/12/2006 to 08/25/2006.

   (b) The Respondent is in violation of Rule 134.600(c)(1)(B) which states in part "The carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care".

3. The Requestor obtained preauthorization which covers the disputed date of service. The Respondent has improperly denied the disputed service.

4. Reimbursement is recommended per Rule 134.202(e)(5)(A)(ii) and 134.202(e)(5)(B)(ii) in the following amount $36.00 x 80% = $28.80 x 8 hours = $230.40.

5. Reimbursement is recommended per Rule 134.202(e)(5)(A)(ii) and 134.202(e)(5)(C)(ii) in the following amount $64.00 x 80% = $51.20 x 8 hours = $409.60.

6. The Respondent has made a payment of $72.16. Additional reimbursement is recommended per Rule Rule 134.202(e)(5)(A)(ii) and 134.202(e)(5)(C)(ii) in the amount of $235.04 ($64.00 x 80% = $51.20 x 6 hours = $307.20 minus Respondent payment of $72.16).

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202 and §134.600

PART VII: DIVISION DECISION AND 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 $875.04 plus accrued interest, due within 30 days of receipt of this Order

ORDER:

		05-25-07
Authorized 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.