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: Southwest Dallas Family Clinic 2815 S. Hampton Road Dallas, Texas 75224	MFDR Tracking #:	M4-07-2450-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name: Fedex Ground Package System Inc. Box #: 22	Date of Injury:	
	Employer Name:	Fedex Ground Package system Inc.
	Insurance Carrier #:	023050000336040001

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "We are exempt from pre-auth; therefore, preauth is not required."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a position summary

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
05-11-06 to 06-02-06	W1 & 62	97545-WC-CA (1 hour @ $36.00 X 2 hours X 11 DOS)	1-3	$792.00
05-11-06 to 05-22-06 and 05-24-06 to 06-02-06	W1 & 62	97546-WC-CA (1 hour @ $36.00 X 2 hours X 10 DOS)	1-3	$720.00
05-23-06	W1 & 62	97546-WC-CA (1 hour @ $36.00)	1-3	$36.00
Total Due:				$1,548.00

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 relates to CPT codes 97545-WC-CA and 97546-WC-CA that the Requestor denied with denial reason "W1" (Workers Compensation State Fee Schedule Adjustment) and "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization).

2. The Requestor submitted documentation verifying that the Requestor is CARF accredited, therefore, no preauthorization of the services in dispute was needed.

3. Reimbursement is recommended per Rule 134.202(e)(5)(B)(ii) as listed above.

A Legal and Compliance referral was made due to the Respondent using an improper denial code.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

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 $1,548.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order by:

04-04-07

Authorized Signature	Medical Fee Dispute Resolution Officer	Date of Decision and Order

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.