**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:<br><br>Allied Behavioral Healthcare<br>P.O. Box 257<br>Ferris, Texas 75125-0257 | MFDR Tracking #: M4-07-2719-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br><br>TPCIGA FOR RELIANCE NATIONAL I NS.<br>BOX 50 | Date of Injury:<br>Employer Name: CRANE PLUMBING LLC<br>Insurance Carrier #: 003960000953750001 |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The attached claim was pre-authorized…We have yet to receive any payment. Please help resolve this…"

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 EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury…"

Principle Documentation:

1. Response to DWC 60

## PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75227 is located in Dallas County.

| Date(s) of Service | Denial Code(s) | CPT Code(s) and Calculations | Part V Reference | Amount Due |
|---|---|---|---|---|
| 8-2-06 | F, R, 51 | 90806 | 1, 2, 3 | $115.00 |
| **Total Due:** | | | | $115.00 |

## 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. These services were denied by the Respondent with reason code "F-Reduction according to fee guidelines," "51-These are non-covered services because this is a pre-existing condition," and "R-Charge unrelated to compensable injury."

2. The carrier denied disputed service due to charge unrelated to compensable injury. The Respondent is disputing the right wrist and cervical. The compensable injury is limited to the right shoulder. The Diagnosis Code which is on the CMS 1500 is 726.1 – Rotator Cuff Syndrome of Shoulder. The Requestor treated the compensable injury of the right shoulder. This is not a pre-existing condition. Reimbursement is recommended per Rule 134.202(d).

3. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge."

**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/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 $115.00 plus accrued interest, due within 30 days of receipt of this Order.

**ORDER :**

| | Donna D. Auby | 5-31-07 |
|---|---|---|
| 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.**