Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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 Rehabilitation Centers 2420 E. Randol Mill Rd. Arlington TX 76011	MFDR Tracking #: M4-07-6796-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: FIDELITY & GUARANTY INSURANCE BOX 19	Date of Injury: Employer Name: CLAYTON HOMES INC Insurance Carrier #: 9000582029

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: ""Provider sent a request for reconsideration... Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No Position Summary was received from the Respondent.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-12-06	147, 112-003, W1, 598, 221	97545-WH ($102.40 x initial 2 hours minus $51.20 carrier reimbursement)	1, 2, 3	$51.20
Total Due:				$51.20

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 revised table of disputed services on 6-25-07. This Table will be used for this review.

1. These services were denied by the Respondent with reason codes "112-003-The primary provider is a non-contracted provider," "147-Provider contracted/negotiated rate expired or not on file," "221-Only one initial treatment code will be allowed per day," "598-The reimbursement for this procedure has been calculated according to the guidelines for a program that is not CARF accredited," and "W1-Workers Compensation State Fee Schedule Adjustment."

2. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 9-27-06 (#4005399) for four weeks of a Work Hardening Program.

3. Per Rule 134.202(e)(5)(A)(ii) reimbursement for non-CARF accredited Programs shall be 80% of the MAR or $51.20 per hour. The first two hours should be billed as one unit per the rule. Additional reimbursement is recommended.

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 $51.20 plus accrued interest, due within 30 days of receipt of this Order.

8-1-07

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.