



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider    () Injured Employee    () Insurance Carrier	
Requestor's Name and Address:  Summit Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-06-1244-01  Claim No.:  Injured Employee's Name:
Respondent's Name and Address:  TX Mutual Insurance Company, Box 54	Date of Injury:  Employer's Name:  Insurance Carrier's No.:

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

Documents include the DWC 60 package. Position paper states, "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." In a letter dated 4-13-06 the requestor withdrew all services that were denied for medical necessity.

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position paper states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
6-14-05, 9-7-05, 5-31-05	97	CPT code 95851	1	\$00.00
9-7-05, 5-31-05	97	CPT code 95833	1	\$00.00
12-1-05	62	CPT code 97545-WH	2	\$102.40
12-1-05	62	CPT code 97546-WH	2	\$204.80
8-10-05	248	CPT code 99080-73	3	\$15.00
<b>Total Due</b>				<b>\$322.20</b>

### PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. The carrier denied this service as "97 - Payment is included in the allowance for another service/procedure." According to the 2002 MFG this procedure is considered by Medicare to be a component procedure of CPT codes 99213 and 97140, which were billed on these dates of service. Recommend no reimbursement.
2. The carrier denied this service as "62 - Payment denied for absence of Precertification/Authorization." Per Rule 134.600 (h) (4), the requestor provided a copy of preauthorization letter dated 11-3-05 for (10) sessions of a work hardening program. A Compliance and Regulations referral will be for inappropriate denial of the preauthorized service. Per Rule 134.202 (e) (5) (A) (ii) reimbursement if \$51.20 per hour.

3. The carrier denied this service as “248-DWC 73 was not properly completed.” The requestor provided documentation to support delivery of services and proper completion of the report per Rule 133.307(g)(3)(A-F).

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. § 413.011(a-d)  
28 Texas Administrative Code Sec. § 134.1, 133.307(g)(3)(A-F), 134.600 (h) (4)

**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 additional reimbursement **in the amount of** \$322.20.

Ordered by:

Donna Auby

4-19-06

Authorized Signature

Typed Name

Date of 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.**