



## 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 76011-6335	MFDR Tracking #: M5-07-0199-01
	DWC Claim #:
	Injured Employee:
DALLAS NATIONAL INSURANCE CO BOX 20	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### 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

Respondent's Position Summary: "Dallas National Insurance company maintains that it complied with the Texas Labor Code and the Rules promulgated by the Division of Workers' Compensation... (It) maintains that it should not be responsible to reimburse Requestor any unnecessary fees."

Principle Documentation:

1. Response to DWC 60
2. EOB(s)

### 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
3-8-06	50, 880-104	97110 (\$34.98 x 3 units)	1, 2	\$104.94
3-8-06	50, 880-104	97140 (\$32.59 x 1 unit)	1, 2	\$32.59
<b>Total Due:</b>				\$137.53

### 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 provided a revised Table of Disputed Services on May 9, 2007 which contained only date of service 3-8-06. This table will be used for this review.

1. These services were denied by the Respondent as "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer," and "880-104-Denied per insurance: Unnecessary treatment. 100%."
2. These services were preauthorized in a letter dated 02-20-06 and corrected letter dated 3-13-06 from IMO. The Respondent denied these services for unnecessary medical treatment. Rule 133.301 (a) states "the Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Recommend reimbursement per Rule 134.202(c)(1).

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rule 133.301(a).

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

Texas Labor Code Sec. §413.011(a-d)  
 28 Texas Administrative Code Sec. §133.301, §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 \$137.53 plus accrued interest, due within 30 days of receipt of this Order.

**ORDER :**

6-6-07

\_\_\_\_\_  
 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.**