



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:  Central Dallas Rehab 3523 McKinney Ave. # 246 Dallas, TX 75204	MFDR Tracking #: M5-07-0516-01
	Previous #: M4-05-3168-1
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
Box #: 42	Employer Name:
	Insurance Carrier #:

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

Requestor's Position Summary: "The initial denials were for entitlement. A copy of the BRC was submitted. Medical Bills will support the claims for serviceeee...."

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: "Please note, at the time these services were delivered, issues of compensability and extent of injury existed... The Respondent is in the process of evaluating the services made the basis of this dispute [sic] per the hearing officer's decision."

Principle Documentation:

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

### PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75207 is located in Dallas County.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
2-26-04 – 3-18-04	D91, E1, 01, F84	99212 (\$48.99 x 11 DOS)	1, 2	\$538.89
2-26-04 – 3-5-04	D91, 01, E1, S55	97110-GP (\$36.98 x 4 units)	2, 3	\$147.92
4-8-04 – 4-12-04	D91, E1, 01, F84	99211 (\$27.86 x 2 DOS)	1, 2	\$55.72
2-27-04	D91, E1, 01, G2	95831-59	4, 5	\$0.00
<b>Total Due:</b>				<b>\$742.53</b>

### 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.

In a letter dated 1-12-07 and an e-mail dated 4-26-07 the Requestor withdrew CPT code 97110 for dates of service 3-8-04 through 3-18-04; CPT code 99211 on 5-3-04, 5-26-04, 6-25-04 and 7-06-04; CPT code 99212 on 5-26-04 and 6-25-04; and CPT code 99080 on 4-19-04. These services will not be a part of this review.

1. These services were denied by the Respondent with reason code "D91-Duplicate Bill," "E1-Entitlement to Benefits," "01-Denial after Reconsideration," and "F84-Fee Guideline MAR reduction."
2. Per the Contested Case Hearing order rendered on 7-15-04, the compensable injury of \_\_\_\_\_ extends to the right hand contusion, crushed right hand, right CMC joint injury, and right radial nerve injury. The Diagnosis codes on the CMS 1500 are 927.2 – Crush Injury to Hand, 727-05 - Tenosynovitis hand/wrist and 729.5 – pain in limb. These services are compensable. Reimbursement is recommended."
3. These services were denied by the Respondent with reason code "D91-Duplicate Bill," "E1-Entitlement to Benefits," "01-Denial after Reconsideration," and "S55-Supplemental Payment."
4. These services were denied by the Respondent with reason code "D91-Duplicate Bill," "E1-Entitlement to Benefits," "01-Denial after Reconsideration," and "G90-Unbundling (Included in Global)."
5. Per Rule 134.202 (b) this procedure is considered to be a component procedure of 99212 which was billed on this date of service. There are no circumstances in which a modifier is appropriate. These services can not be billed separately. No 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 \$742.53 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

5-8-07

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