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

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Alpine Healthcare, L. P. 1621 N. Main Ave. Ste 5 San Antonio, TX 78212	MDR Tracking No.: M4-05-0187-01 Claim No.: Injured Employee's Name:
Respondent's Name: SAN ANTONIO ISD, BOX 04	Date of Injury: Employer's Name: SAN ANTONIO ISD Insurance Carrier's No.: 03103370

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "Provider sent a request for reconsideration... Proof that carrier received request is also included."

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "Please note that the amounts billed were all processed and paid per the medical policies and fee guidelines in effect on that date."

Principle Documentation:

1. DWC 60 package

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)
12-15-03	F	97035	1, 2	$14.21
10-30-03 - 12-15-03	F, 135	G0283 ($14.91 x 6 units)	1, 3	$89.46
Total Due				$103.67

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

In e-mails dated 2-27-07 and 3-8-07 the Requestor withdrew dates of service 1-15-04, 10-02-03 and 10-17-03. These services will not be a part of this review.

1) These services were rendered in Harris County.

2) The Respondent denied these services as "F-Fee Guideline MAR Reduction." The Respondent made no payment. Recommend reimbursement per Rule 134.202(c)(1) of $14.21.

3) The Respondent denied these services as "F-Fee Guideline MAR Reduction," and "135-reduced per administrative rules." The Respondent made no payment and gave no valid reason for not doing so. Recommend reimbursement per Rule 134.202(c)(1).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 134.1, 134.202

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 reimbursement. The Division hereby **ORDERS** the Respondent to remit the amount of $103.67 to the Requestor within 30 days of receipt of this Order.

Decision and Order by:

	Donna Auby, Medical Fee Dispute Officer	4-27-07
Authorized Signature	Typed Name	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.