Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL 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: South Coast Spine and Rehabilitation, P.A. 620 Paredes Line Rd Brownsville, TX 78521	MDR Tracking No.: M4-05-0734-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Association of School Board Rep Box #12	Date of Injury: Employer's Name: Los Fresnos Cons. ISD Insurance Carrier's No.: 00025-001-103-1808854 (BAE)

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Requestor's position statement
2. Form 60
3. EOB's
4. CMS 1500 Forms
5. Additional information received by the Requestor

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Respondent did not submit a response or position statement

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)
04/05/04 06/23/04	N N	99080-73 99080	1, 2	$15.00 $23.50
TOTAL DUE				$38.50

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

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

1. The carrier denied the Form 73 as not appropriately documented. The requestor has submitted a copy of the Form 73. Part III of the Form 73 should be completed only if box 13(b) is checked. The requestor has completed the Form 73 accordingly and therefore, is entitled to a reimbursement of $15.00.
2. The carrier denied CPT code 99080 as not appropriately documented, requiring a description. In the requestor's additional information, it is stated that this service is for copies of medical records for a Designated Doctor's exam. A copy of the letter requesting the Designated Doctor's exam was also included. The CMS 1500 form clearly shows 47 copies billed, therefore, requestor is entitled to a reimbursement of $23.50.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §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 additional reimbursement **in the amount of $38.50.**

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Benita Diaz	

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.