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:	MDR Tracking No.: M4-05-1637-01
South Coast Spine & Rehabilitation, PA 620 Paredes Line Rd. Brownsville, TX 78521	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Co. Rep Box #: 54	Date of Injury:
	Employer's Name: Valley Fruit & Vegetable Co., Inc.
	Insurance Carrier's No.: 99D/363085

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor states in part, "…No TWCC-62 forms are enclosed behind this section because no Explanation of Medical Benefits (TWCC-62) forms were received. Enclosed is convincing evidence that the carrier did receive our complete medical bills VIA FEDERAL EXPRESS TRACKING #'s 7906-9244-2859 signed for by L. Varela. The carrier has had the complete medical claim in their possession for over 45 days…"

Principle Documentation:

1. DWC-60 Packet

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent states in their response to the initial dispute on the Table of Disputed Services that "proper bill not received, reduced, or denied. Proper request for reconsideration not received".

Principle Documentation: 1. DWC-60 response

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)
07/01/04	No EOB	97750-FC	1	$548.80
TOTAL DUE				$548.80

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. CPT Code 97750-FC for date of service 07/01/04. Neither party submitted EOBs; therefore this dispute will be reviewed according to Rule 133.307 and Rule 134.202. The Respondent has indicated in their response they did not receive a request for reconsideration for this date of service. Per Rule 133.307(e)(2)(B) the Requestor has submitted convincing evidence that request for reconsideration was made to the Respondent. Per Rule 134.202(e)(4) the Requestor submitted the FCE report support the services were rendered as billed. Therefore, per Rule 134.202(b)reimbursement in the amount of $548.80 ($27.44 x 125% = $34.30 x 16 units) is recommended.

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 $548.80.**

Ordered by:

	Marguerite Foster	May 5, 2006
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.