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: Azalea Orthopedic and Sports Medicine 3414 Golden Road Tyler, TX 75701	MDR Tracking No.: M4-05-2900-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Casualty Co. C/o Burns, Anderson, Jury & Brenner Rep Box #: 47	Date of Injury: Employer's Name: Cendant Corporation Insurance Carrier's No.: 3C809145

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "We have called and faxed a request for payment or denial… but no effort from the insurance company has been made to process these claims on dates of service listed above. We seek resolution regarding payment for these dates of service… Per definition of Rule 133.304(a), it states than an insurance carrier has to take final action on a medical bill no later than the 45th day after the date the insurance carrier receives a complete bill…"

Principle Documentation:

1. Requestor's position summary
2. CMS-1500
3. Fax confirmation sheets – Requests for Reconsideration

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondents position summary states, "Please be advised the attached medical dispute is over 1 year old. I 'Request for Dismissal – Bill is stale'."

Principle Documentation: 1. Respondent's position summary

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)
09/18/03	None	99203 – E&M – New Patient	1	$107.55
09/18/03 & 10/20/03	None	99080-73 – Work Status Report	2	$30.00
10/20/03	None	99212 – E&M	3	$53.00
TOTAL DUE				$190.55

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

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

This dispute relates to CPT Codes 99203, 99212 and 99080-73 (office visits and Work Status reports). Neither party submitted EOBs and the insurance carrier states that the disputed dates of service are over a year old. According to §133.307(d)(1) the dispute was received in Medical Dispute Resolution on September 8, 2004; the disputed dates of service are September 18th and October 20th which is within the one-year filing deadline; therefore, the disputed dates of service will be reviewed in accordance with the 2002 Medical Fee Guideline.

1. The clinical notes submitted for date of service 09/18/03 supports the services were rendered as billed. Therefore, reimbursement is recommended in the amount of $107.55.

2. Review of the Work Status Reports indicates they were filed according to §129.5(d)(1-2); therefore, reimbursement is recommended in the amount of $30.00 ($15.00 x 2).

3. The clinical notes submitted for date of service 10/20/03 support the services were rendered as billed. Therefore, reimbursement in the amount of $53.00 is recommended.

Therefore it is the conclusion of the Medical Review Division that reimbursement in the amount of $190.55 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §133.307
28 Texas Administrative Code Sec. §129.5(d)(1-2)

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 $190.55. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Marguerite Foster	November 10, 2005
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.