**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

| | |
|---|---|
| Requestors Name and Address:<br>Dallas Injection and Diagnostics<br>5445 La Sierra Drive, Suite 204<br>Dallas, Texas 75231 | MDR Tracking No.: M4-05-3204-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name:<br>Insurance Company of the State of PA<br>Rep Box # 19 | Date of Injury: |
| | Employer's Name: J B Hunt Transport Inc. |
| | Insurance Carrier's No.: 149132961 |

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

Requestor's Position Summary states in part, "Since bills and reconsideration were rendered in good faith effort we are asking for our claims to be reconsidered."

Principle Documentation: 1. DWC 60 package
2. Explanation of Benefits

## PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "…Without documentation, carrier cannot determine the proper fee for the procedure (whatever it was) and cannot determine what supplies are or are not included in the procedure code."

Principle Documentation: 1. Response to DWC 60

## 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) |
|---|---|---|---|---|
| 02-25-04 | N | 99499, 76005, A4452, A4305, A4550, 97010, E0230, J3301, J3490, J2001, A4641 and 99070 | 1 & 3 | NA |
| 02-25-04 | 2 | A4202 | 2 & 3 | NA |
| TOTAL DUE | | | | |

## 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, sets out reimbursement guidelines.

(1) The services were denied by the Respondent with denial code "N" (this charge was denied because an invalid procedure code was submitted on this bill).
(2) The service was denied by the Respondent with denial code "2" (this procedure code or National Drug Code (NDC) is not valid for this date of service. Resubmit bill with a valid procedure code or National Drug Code (NDC).
(3) Per Rule 133.307(2)(A) the copy of the request for a Medical Fee Dispute shall include a copy of all medical bill(s) as originally submitted to the carrier for reconsideration. This dispute did not contain a copy of the medical bill(s), therefore is not a complete medical fee dispute and no review by Medical Dispute Resolution will be performed.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202 and 133.307(2)(A)

**PART VII: DIVISION FINDINGS AND DECISION**

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 not entitled to reimbursement for the services involved in this dispute.

**Findings and Decision by:**

| | | 11-29-06 |
|---|---|---|
| Authorized Signature | Typed Name | Date of Findings and Decision |

**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.**