



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: Southwest Center Medical 7125 Marvin D. Love, Suite 107 Dallas, Texas 75237	MDR Tracking No.: M4-05-3233-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas County C/o Harris & Harris Rep Box # 42	Date of Injury:
	Employer's Name: Dallas County
	Insurance Carrier's No.: 10814

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Documentation supports level of care."

Principle Documentation:

1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Report dated 08/19/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"...N—Not Appropriately Documented..."

Principle Documentation:

1. Respondent's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits

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)
08/19/04	N	99213	1	\$68.24
TOTAL DUE				\$68.24

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. Code 99213 for date of service 08/19/04 denied as "N—Not appropriately documented". Carrier reimbursed the Requestor \$00.00. The Requestor submitted medical records to substantiate the level of service billed. Per Rule 134.202(b), reimbursement in the amount of \$68.24 ($\$54.59 \times 125\% = \68.24) is allowed. Therefore, reimbursement in the amount of \$68.24 is recommended.

Therefore, it is the conclusion of the Medical Review Division that reimbursement in the amount of \$68.24 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. §134.201
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 **\$68.24**. 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:

01/20/06

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.