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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Julio Fajardo, DC 6316 Azle Avenue Suite 600 Fort Worth, TX 76134	MFDR Tracking #: M4-05-3344-01 (previous M4-04-B164-01 & M4-04-A608-01) DWC Claim #: Injured Employee:
Respondent Name and Box #: Federal Insurance Co. Rep Box # 17	Date of Injury: Employer Name: Mouser Electronics Inc. Insurance Carrier #: 7170198943

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…Work Conditioning appropriately documented…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a position summary but the Table of Disputed Services states: "Not appropriately documented".

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
09/08-09/26/03	N, O	97545-WC	1	$806.40
09/08-09/26/03	N, O	97546-WC	2	$1180.80
Total Due:				$1987.20

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, Reimbursement Policies and Guidelines, and Division Rule 134.202 titled, Medical Fee Guideline effective August 1, 2003, sets out the reimbursement guidelines.

1. This dispute is related to CPT code 97545-WC for dates of service 09/08-09/26/03 that was denied with "N-Not appropriately documented", "O-Denial after reconsideration". The Requestor's documentation clearly supports the

services were rendered as billed. Per Rule 134.202(e) (5) (A)(ii),(5) (B) additional reimbursement in the amount of $806.40 ($28.80/hour x 28 hours) is recommended.

2. This dispute is related to CPT code 97546-WC for dates of service 09/08-09/26/03 that was denied with "N-Not appropriately documented", "O-Denial after reconsideration". The Requestor's documentation clearly supports the services were rendered as billed. Per Rule 134.202(e) (5) (A)(ii), (5) (B) additional reimbursement in the amount of $1180.80 ($28.80/hour x 41 hours)is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION DECISION AND/OR 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$1987.20** plus accrued interest, due within 30 days of receipt of this Order.

Order:

05/10/2007

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.