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: Pedro Nosnik, M.D. 4100 W. 15th Street, Suite 206 Plano, Texas 75093	MDR Tracking No.: M4-05-4142-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company Rep Box # 19	Date of Injury: Employer's Name: Dixie Staffing Services Insurance Carrier's No.: 001627018078WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary as stated on the Table of Disputed Services states, "Fee issue, Carrier will not pay at correct Fee Schedule."

Principle Documentation:
1. DWC 60 package
2. CMS 1500s
3. Medical Records

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's Position Summary as states in part, "…The amount paid was reduced to align payment with state fee guidelines… "

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)
06/11/04	F	99244	1-2	$00.00
TOTAL DUE				$00.00

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. This dispute relates to CPT code 99244 for date of service 06/11/04 and was denied as "F—reimbursement has been calculated according to State Fee Schedule."

2. The Respondent reimbursed the Requestor $203.39. Per Rule 134.202(c)(1), reimbursement in the amount of $203.39 ($162.71 x 125%) is allowed. Per Rule 134.202(c)(1), no additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section §413.011(a-d)
28 Texas Administrative Code Sec. §134.1
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 not entitled to additional reimbursement.

Decision by:

		11/30/06
Authorized Signature	Typed Name	Date of 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.