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: First Rio Valley Medical, P.A. 620 Paredes Line Rd. Brownsville, TX 78521	MDR Tracking No.: M4-05-4561-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Travelers Indemnity Co. of Connecticut Rep Box #05	Date of Injury: Employer's Name: Brownsville ISD Insurance Carrier's No.: 478 BPA6252-J

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Requestor's position statement
2. Form 60
3. EOBs
4. CMS 1500 form

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. No position statement or documentation submitted.

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)
02/26/04	D	99213-25 97140-59	1	$59.00 $30.90
TOTAL DUE				$89.90

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. The requestor claims they have never received an EOB with a specific denial other than Duplicate bill. The carrier did not respond to their request for medical dispute resolution. The requestor has submitted documentation as convincing evidence that the carrier has received their request for original EOB and reconsideration per Rules 133.307 (e) (2) (B) and 133.307 (g) (3) (A), therefore, reimbursement is recommended for both the office visit, 99213-25, & therapeutic activity 97140-59.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
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 $89.90.**

Ordered by:

	Benita Diaz	
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.