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: John B. Payne, D.O. P.O. Box 879 Bedford, TX 76095	MDR Tracking No.: M4-05-4991-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Sentry Insurance Rep Box # 42	Date of Injury: Employer's Name: Kimberly Clark Corp. Insurance Carrier's No.: 51C246681

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states the Dr. is a designated Dr.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a position summary.

Principle Documentation: 1. TWCC-60 Response

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)
10/25/04	D,F	99212	1	$32.00
TOTAL DUE				$32.00

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. CPT Code 99212 for date of service 10/25/04. The insurance carrier denied with payment exception codes of "D & F". Review of submitted CMS-1500 reveals the requestor stamped the CMS-1500 as "Rebill-submitting for reconsideration". Per 133.304 (k)(1)(A) the requestor is to mark the bill with "Request For reconsideration". When a requestor stamps their CMS-1500 with "Rebill" this indicates a change in the bill, and the reason the carrier denied as a duplicate bill. The payment exception code of "F" indicates services were paid per the fee guideline; however no payment was made. Therefore per Rule 134.202(b) reimbursement in the amount of $32.00 is recommended.

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 $32.00.**

Ordered by:

Authorized Signature	Typed Name	03/03/06 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.