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: Daniel Shalev, M.D./Southwest Pain Institute P. O. Box 803311 Dallas, Texas 75380	MDR Tracking No.: M4-05-6557-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: City of Carrollton C/o J. T. Parker & Associates, LLC Rep Box # 01	Date of Injury: Employer's Name: City of Carrollton Insurance Carrier's No.: 2420012

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Please see attached office notes, This company has been processing are [our] claim for months. They always say they need to pull the file and will call back and they never do."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Office Visit Report dated 05/21/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Dr. Shalev did not see claimant on this DOS."

Principle Documentation:
1. Respondent's position summary
2. TWCC-60/Table of Disputed Services

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)
05/24/04	No EOBs	99213 (Office Visit, Established Patient)	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 05/24/04 was denied reimbursement by the carrier for an undetermined reason. Neither the Requestor or the Respondent submitted EOBs for this CPT code for this date of service, therefore, this CPT code will be reviewed according to the Medical Fee Guideline. The Requestor submitted medical records to substantiate the level of service billed. Carrier reimbursed the Requestor $00.00. Per Rule 134.202, reimbursement shall be according to Medicare plus 125% ($54.59 x 125% = $68.24). Therefore, reimbursement in the amount of $68.24 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 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:

Authorized Signature	Typed Name	05/18/06 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.