



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestors Name and Address: Nicolas Padron, M.D. 7125 Marvin D. Love # 107 Dallas, TX 75237	MDR Tracking No.: M4-05-8053-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: TPCIGA For Reliance National Insurance Rep Box # 50	Date of Injury:
	Employer's Name: Aramark Corp.
	Insurance Carrier's No.: 900915763

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "...Dr. Padron is an appropriate health care provider..."

Principle Documentation: 1. DWC 60 package
 2. CMS 1500's
 3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a response.

Principle Documentation: 1. N/A

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)
08/23/04	K	99213-Office Visit	1	\$68.24
12/27/04	K	99212-Office Visit	2	\$48.99
TOTAL DUE				\$117.23

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. CPT Code 99213 for date of service 08/23/04 denied with "K-Not appropriate health care provider" Upon reconsideration the denial remained the same. EOB was also denied with the same code. Therefore per Rule 134.202(b) (c) (1) reimbursement in the amount of \$68.24 (\$54.59 x 125%) is recommended.
2. CPT Code 99212 for date of service 08/23/04 denied with "K-Not appropriate health care provider" Upon reconsideration the denial remained the same. Therefore per Rule 134.202(b) (c) (1) reimbursement in the amount of \$48.99 (\$39.19 x 125%) 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
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 **\$117.23**. 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:

01/26/2007

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.