Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Jacob Rosenstein, M.D. 800 W. Arbrook Blvd. # 150 Arlington, TX 76015	MFDR Tracking #: M4-05-8089-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Travelers Indemnity Co. of Conn. Rep Box # 05	Date of Injury: Employer Name: Citation Corp Insurance Carrier #: 039CBBKT6721

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Table of Disputed Services Rationale states "…MAR Is $91.04 and both codes were billed with the -50 modifier which indicates it was done bilaterally, so the 150% payment adjustment applies…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response.

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76017 is located in Tarrant county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
02/10/05	W1/W1	64623-50	1	$30.35
02/10/05	W1/W1	64623-50	2	$30.35
Total Due:				$60.70

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. "W1- Workers Compensation State F/S Adj. reimbursement based on max allowable fee for this proc. Based on medical F/S or if on is not specified UCR for this zip code area" & "W1-Workers Compensation State Fee Schedule adjustment. This bill has been processed correctly per the State fee schedule."

2. The MAR is $91.04 x. The carrier made payment of $121.38. Per Rule 134.202 (c) (1) additional reimbursement in the amount of $60.70 is recommended for this bilateral procedure ($48.55 x 125%=$60.69 x 150%=$91.04 x 2 $182.08 - $121.38 carrier reimbursement =$60.70).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION DECISION AND/OR 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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$60.70** plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

		05/03/04
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.