Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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:	MFDR Tracking #: M4-05-9532-01
Dr. Andrew Small, M.D. P.O. Box 1404 Decatur, TX 76234	DWC Claim #: Injured Employee:
Respondent Name and Box #: Hartford Underwriters Insurance Rep Box #: 27	Date of Injury: Employer Name: REVENUE TECHNOLOGY SERVICES Insurance Carrier #: 978C 55860

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We have only submitted the initial bill, and the request for reconsideration. We have not submitted any other duplicate bills for services rendered, and we do not have any record of a prior denial or payment for services included in the request for reconsideration."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent has not submitted a Position Summary; however, the Respondent's rationale on the Table of Disputed Services states: "No request for recon."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
06/14/04	D	99213 ($54.59 x 125%)	1-4	$68.24
Total Due:				$68.24

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, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "D – Reimbursement was previously made for services rendered to this injured worker on this date of service."

2. The Respondent did not respond to the Division with documentation to support their denial "D – Reimbursement was previously made for services rendered to this injured worker on this date of service."

3. The Requestor submitted convincing evidence of carrier receipt of "Request for Reconsideration" in accordance with 133.307(e)(2)(B). Therefore, per Rule 134.202(c)(1), reimbursement is recommended

4. Per review of Box 32 on CMS-1500, zip code 75050 is located in Dallas County.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §134.1, §134.202

PART VII: DIVISION 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 $68.24 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		07/12/07
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.