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: WolMed 7125 Marvin D. Love Fwy #107 Dallas, Texas 75237	MFDR Tracking #: M405-9580-01 Former Tracking: DWC Claim #: Injured Employee:
Respondent Name and Box #: Federal Insurance Co. c/o Downs Stanford PC Box #17	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary states in part "Documentation attached meets the criteria set forth by TWCC guidelines."

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 file a response.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10/07/03	N,O,940	97110-GP ($35.90x 1unit)	1	$35.90
10/07/03	N,O,940	97530-GP ($36.48 x 1 unit)	1	$36.48
10/07/03	N,O,940	97003 ($100.48 x 1 unit)	1	$100.48
Total Due:				$172.86

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.

Per Box 32 of the CMS-1500 services were performed in Dallas County zip code 75237.

1. These services were denied by the Respondent with reason code "N-Not Appropriately Documented". Upon request for reconsideration, reimbursement was denied based upon "640-Re-evalution – no additional payment recommended", "O-Denial after reconsideration" , "N-Not Appropriately Documented" and "Per Medicare/LMRP guidelines, timed units of physical medicine must include documentation of the amount of time spent on accumulative basis. LMRPY-13.3"

- The treatment notes state "Therapeutic activities, 1-on 1 for 1 unit were performed on the patient…" The medical documentation provided as required by Rule 133.307(g)(3)(B) supports the delivery of services as billed. Reimbursement is recommended per Rule 134.202(c)(1).

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 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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $172.86 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		06/05/07
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.