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: Azalea Orthopedic and Sports Medicine 3414 Golden Road Tyler, TX 75701	MDR Tracking No.: M4-05-A051-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Indemnity Insurance Co. C/o ACE USA/ESIS Box 15	Date of Injury: Employer's Name: Trinity Industries, Inc. Insurance Carrier's No.: 4650179986

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…We have and faxed a request for payment or denial… but no effort from the insurance company has been made to process this claim on date of service 07/06/04. We seek resolution regarding payment for this date of service…"

Principle Documentation:

1. TWCC-60
2. Requestor's position summary
3. CMS 1500's
4. MMI report

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a position summary; however, the Respondent's rationale on the Table of Disputed Services states, "Bill will be submitted for processing."

Principle Documentation: 1. TWCC-60 response

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
07/06/04	CPT Code 99456-WP-V2 – MMI/IR	1	$353.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) entitled (Guidelines and Medical Policies), and Commission Rule 134.202 entitled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

This dispute relates to CPT Code 99456-WP-V2 (MMI/IR). Neither party submitted EOBs. Per §133.307(e)(2)(B) the requestor has submitted fax confirmation sheets indicating a request for reconsideration. The Respondent indicated in their response to the dispute that the bill was be submitted for processing. In communications with the Requestor, they have not received payment for this date of service.

1. Per §134.202(e)(6)(C)(i)(1) and (iii) the submitted MMI/IR report supports services were rendered as billed.

Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of $353.00 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. 134.202(e)(6)(C)(i)(1) and (iii)
28 Texas Administrative Code Sec. 133.307(e)(2)(B)

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 $353.00. 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:

	Marguerite Foster	November 10, 2005
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.