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

Requestors Name and Address:	MDR Tracking No.:	M4-05-A325-01
Eric A.VanderWerff, D.C. 615 N. O'Connor Road, Suite 12 Irving, Texas 75061	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: Employers Mutual Casualty Company Rep Box # 19	Date of Injury:	
	Employer's Name:	Baker Drywall Company Inc
	Insurance Carrier's No.:	IW4A0005601

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Appropriately Documented."

Principle Documentation:
1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable…"

Principle Documentation: 1. Response to DWC 60

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)
03-29-05	16/225	95903-TC (1 unit @ $47.84 X 6 units – payment of $273.45)	(1,3,5,6)	$13.59
03-29-05	16/225	95927-TC-59 (1 unit @ $48.84 X 5 units)	(1-4)	$244.20
03-29-05	16/225	95925-TC-59 (1 unit @ $48.84 X 2 units – payment of $88.78)	(1,3,5,6)	$8.90
03-29-05	16/225	95904-TC (1 unit @ $48.34 X 6 units – payment of $219.48)	(1,3,5,6)	$70.56
03-29-05	16/225	95934-TC (1 unit @ $11.58 X 2 units)	(1,3, & 7)	$0.00
TOTAL DUE				$337.25

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) The service billed was denied by the Respondent with denial codes "16" (claim/service lacks information which is needed for adjudication) and "225" (the submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information).
(2) The Respondent has not made a payment.
(3) Per Rule 133.307 the Requestor submitted documentation for review which supported the service billed.
(4) Per Rule 134.202(c)(1) reimbursement is recommended in the amount listed above.
(5) The Respondent has made a partial payment.
(6) Additional reimbursement is recommended in the amount listed above per Rule 134.202(c)(1).

(7) The Requestor has made a payment of $48.06. No additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202(c)(1) and 133.307

PART VII: DIVISION FINDINGS 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 in the amount of $337.25. The Division hereby **ORDERS** the Respondent 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.

Order by:

		12-08-06
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.