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: Nicholas Padron, MD 7125 Marvin D Love #107 Dallas, TX 75237	MDR Tracking No.: M4-05-A752-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Protection Insurance, Box 42	Date of Injury: Employer's Name: Providian National Bank Insurance Carrier's No.: 465CP169763

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

The Position Summary states, "…Our charges were not paid according to TWCC MFG MAR..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: DWC 60 response.

The Position Summary states, "Fair and reasonable reimbursement made per Rule 413.011(b) and 133.304(1) and 133.305(i)(l)(G)."

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)
9-27-04	F, 18	CPT code 99455-V5-WP	1,2,3,4	$300.00
TOTAL DUE				$300.00

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

1. Per Rule 134.202(e)(6)(D)(iii)(II), the IR is billed and reimbursed at $300.00 for the first musculoskeletal body area if full physical evaluation with range of motion is performed. Review of the IR report revealed that the ROM testing method was performed.

2. Recommend additional reimbursement of $300.00 for the IR. The Respondent has reimbursed the Requestor for the office visit.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.100
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.202 (e)(6)(C) and (D)

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 $300.00.** 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:

	Donna Auby, Medical Dispute Officer	7-21-06
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.