Texas Department of Insurance, Division of Workers' Compensation
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: Pedro Nosnik, MD, PA 4100 W. 15th St., Ste. 206 Plano, TX 75093	MFDR Tracking #: M4-07-0823-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: American Protection Insurance Rep. Box # 42	Date of Injury: Employer Name: Peterson Manufacturing Co. Insurance Carrier #: 4650172591

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:
"No EOB or Payment received."
Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary:
None submitted.

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75220 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
2-7-06	No EOB	99213	1-2	$68.25
Total Due:				

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, sets out the reimbursement guidelines.

1. Review of services revealed neither party submitted an EOB. Per Rule 133.307(e)(2)(b), the Requestor submitted convincing evidence of carrier's receipt of the Requestor's request for an EOB; therefore, the disputed service will be reviewed in accordance with the Division's *Medical Fee Guideline.*

2. CPT code 99213 is used for billing an established office/outpatient visit with a MAR of $68.25, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION DECISION AND/OR 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 $68.25 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

	Elizabeth Pickle, RHIA	May 31, 2007
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.