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: Physicians ASC 403 Treeline Pk # 100 San Antonio, Texas 78209	MFDR Tracking #: M4-07-1170-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Commerce & Industry Insurance Rep Box # 19	Date of Injury: Employer Name: RKJ Construction Inc Insurance Carrier #: 710077132

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Did not pay @ 50% of grouper 1. Did not pay @ 50%. Pd as primary incorrect. Did not pay add on code multi-procedure @ 50%.

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: "Attached is the completed DWC-60. Also attached are the EOBs and explanation of the manner of reimbursement under the ASC Fee Guideline."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
03-28-06	W1/42	64405-SG-59	1 - 3	$277.98
03-28-06	W1/42	64480-SG-59	1, 3, 4	$00.00
03-28-06	W1/42	64480-SG-59	1, 3, 4	$00.00
Total Due:				$277.98

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Ambulatory Surgical Center Fee Guideline*, amended to be effective March 10, 2005, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "W1" (Workers Compensation State Fee Schedule Adjustment) and "42" (Charges exceed our fee schedule or maximum allowable amount).

2. Per Rule 134.402(b-c) additional reimbursement is recommended in the amount of **$277.98.**

   CPT code 64405-SG-59 (Group 1 and locality 07) = $277.98 ($320.04 x 213.3% = $682.64 paid at 50% = $341.32 minus payment of $63.34).

3. Per review of Box 32 on CMS-1500 zip code 78209 is located in Bexar County locality 07.

4. Reimbursement for CPT code 64480-SG-59 per Rule 134.402(b-c) is $682.64 ($320.04 x 213.3% = $682.64 paid at 50% = $341.32 x 2 units = $682.64). The Respondent has made a payment in the amount of $682.65. No additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1 and §134.402

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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $277.98 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		08-01-07
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.