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 Name and Address: Diagnostic Neuroimaging 800 W. Arbrook Blvd. # 300 Arlington, TX 76015	MFDR Tracking #: M4-07-1432-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Amcomp Assurance Corp. Rep Box # 34	Date of Injury: Employer Name: Pro Build Electric Inc. Insurance Carrier #: 1000114963

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Service paid separately, preauthorization obtained.

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: Respondent states in part "…this bill was audited and denied correctly according to DWC Rule 134.202…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
01/26/06	B15,W4,W9	72131-TC-Tomography	1-3	$293.40
Total Due:				$293.40

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. This dispute related to CPT code 72131-TC denied with reason codes "B-15-Procedure/Service is not paid separately", and "W4-No additional Payment allowed after review" . Upon reconsideration, the denial reasons were the same plus "W9-Unnecessary medical treatment."

2. The Requestor received pre-authorization for CPT Code 72131. Per Rule 133.301(a) the Respondent shall not retrospectively deny services that have been preauthorized.

3. Per Rule 134.202 (b) the procedure is not considered a component of any other service billed on the same day. Therefore, per Rule 134.202(c) (1) reimbursement in the amount of $293.40 (234.72 x 125%) is recommended.

A referral has been submitted to Legal & Compliance.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202
28 Texas Administrative Code Sec. §133.301

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 **$293.40** plus accrued interest, due within 30 days of receipt of this Order.

Decision:

05/10/2007

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.