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: Kyle E. Jones, M.D. 1055 Clarksville Street Suite 160 Paris, TX 75460-6085	MFDR Tracking #: M4-07-1839-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Indemnity Insurance Co. Rep Box # 15	Date of Injury: Employer Name: Sara Lee Corp. Insurance Carrier #: C135C6723321

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Requestor did submit a position summary but the Table of Disputed Services Rationale states in part: "… NP saw patient –not MD but TDI does not differentiate between the two should be paid @ 125% of Medicare reimbursement irregardless of a nurse practitioner seeing the patient…"

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: States in part "…Carrier stands by the allowance recommended on the Explanation of Review and the revised Explanation of Review as reimbursement calculated according to state fee schedule guidelines…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75460 is located in Lamar county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
04/06/2006	W1	99213		$9.24
04/13/2006	W1	99213		$9.24
05/01/2006	W1	99213		$9.24
Total Due:				$27.72

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.

Per Rule 133.307 (d)(1) dates of service 04/06/06, 04/13/06, 05/01/06 were timely filed and are eligible for review.

1. These services were denied by the Respondent with reason code "W1-Workers Compensation State Fee Schedule Adjustment".

2. CPT code 99213 according to Rule 134.202 reimbursement is $61.63 ($49.30x 125%), the Respondent made a payment of $52.39 x 3 dates of service. Therefore per Rule 134.202 (d) (1) additional reimbursement in the amount of $27.72 ($52.39 x 3) 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 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 additional amount of **$27.72** plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

06/20/2007

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.