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: Ryan Potter, M.D. 5734 Spohn Dr Corpus Christi, TX 78414-4116	MFDR Tracking #: M4-07-1937-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Zurich American Insurance Co Rep Box #: 19	Date of Injury: Employer Name: Insurance Carrier #: 2720023120

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor has not submitted a Position Summary; however, the Requestor's rationale on the Table of Disputed Services states: "Physician saw the patient for an office visit for their compensable injury. According to TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury."

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: "There are underlying extent of injury issues. In particular, the carrier contends that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury."

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
07/26/06	W12, 852, W4, 282	99213 ($49.30 x 125%)	1-3	$61.63
Total Due:				$61.63

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, set out the reimbursement guidelines.

1. This service was denied by the Respondent with reason code "W12 – Extent of injury. Not finally adjudicated; 852 – Payment Disallowed. Extent of injury not finally adjudicated" and "W4 – No additional reimbursement allowed after review of appeal/reconsideration; 282 – The insurance company is reducing or denying payment after reconsidering a bill."

2. A review of DWC records revealed that the Respondent has not filed a PLN11 form disputing extent of injury issues. This information was verified with Adjustor Randy Hansen, who confirmed that no extent of injury issues exist on this claim; therefore the insurance carrier inappropriately denied reimbursement based on denial reason W12. Per Rule 134.202(c)(1) reimbursement in the amount of $61.63 is recommended.

3. Per review of Box 32 on CMS-1500, zip code 78414 is located in Nueces County.

A Legal and Compliance referral has been made.

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 amount of $61.63 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		07/20/07
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.