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: Ryan Potter, M. D. 5734 Spohn Drive Corpus Christi, Texas 78414-4116	MFDR Tracking #: M4-07-2766-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO BOX 19	Date of Injury: Employer Name: ACADEMY LTD Insurance Carrier #: 2230120117

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): Rationale A: Preauthorization was obtained prior to services being rendered. According to TWCC Fast Facts, if pre-approval was obtained for a compensable injury, approval guarantees payment."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control…The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further the carrier challenges whether the charges are consistent with applicable fee guidelines."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78414 is located in Nueces County.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
2-14-06	No EOB	64483	1, 2	$420.06
2-14-06	No EOB	64484	1, 2	$202.12
2-14-06	No EOB	76005-WP	1, 2	$93.63
Total Due:				$715.81

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.

In an e-mail dated 5-8-07 the Requestor withdrew HCPCS Codes J1040 and J3010. These services will not be a part of this review.

1. Neither the Respondent nor the Requestor provided EOB's for these services. The Requestor submitted convincing evidence of carrier receipt for "Request for Reconsideration EOBs" in accordance with 133.307 (e)(2)(B).

2. Per Rule 134.600 (h), the Requestor provided a copy of a preauthorization letter dated 2-02-06 authorizing "lumbar transforaminal esi." The Respondent did not reimburse the Requestor for these services. This review will be according to Rule 134.202.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §134.1, §134.202, §134.600

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 $715.81 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

5-11-07

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.