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: Linden Dillin, M.D. 900 12th Avenue Fort Worth, Texas 76104	MFDR Tracking #:	M4-07-3434-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name: Continental Casualty Company Box #: 47	Date of Injury:	
	Employer Name:	Sprint Nextel Corporation
	Insurance Carrier #:	690C70397

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "*See authorization for surgery* patient had a legitimate work related injury to …All of these charges are reimbursable."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: There is no position summary from the Respondent

Principle Documentation: The Respondent did not submit a response to the DWC 60 to MFDR.

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76104 is located in Tarrant county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
06-21-06	W9	23455	1 - 3	$1,295.46
06-21-06	W9	29999-59	1, 2 & 4	Refer to reference # 4 for reimbursement recommendation
Total Due:				$1,295.46 and per Rule 134.202(c)(6)

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.

The Requestor withdrew CPT code 73030 billed for date of service 07-10-06 and 08-07-06 and CPT code 99212 billed for date of service 09-29-06; therefore these services will not be part of the review by MFDR.

1. These services were denied by the Respondent with reason code "W9" (unnecessary med treatmnet [sic] based on peer review. Peer review obtained by the carrier ind treatmnt [sic] to be medically unreasonable and/or unnecessary and documented srvc does not meet fee guide contained W/I appli AMA CPT/HCPCS guide.

2. The service billed was preauthorized (number 161343) prior to the Requestor rendering the service. The Respondent is in violation of Rule 134.600(c)(1)(B) which states in part "The carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care".

3. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of $1,295.46.

4. Reimbursement is recommended per Rule 134.202(c)(6) which states "for products for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments".

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600(c)(1)(B) as noted in reference number two (2) above.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $1,295.46 and reimbursement per Rule 134.202 (c)(6) plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05-16-07
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.