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: The Neuromuscular Institute of Texas-PA 9502 Computer Drive, Ste. 100 San Antonio, TX 78229	MFDR Tracking #: M4-07-3808-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: City of San Antonio Box #42	Date of Injury: Employer Name: City of San Antonio Insurance Carrier #: 215826X1

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "A DWC 73 was submitted by the treating doctor on DOS 9/6/06, as required under Rule 129. A first denial was received by our office which denied reimbursement for explanation code D19 – claim/service lacks physician/operative or other supporting documentation. Being not very sure what this exactly meant, we assumed that the carrier did not receive a DWC 73. We then submitted a rebill request which included another copy of the 73 as well as our stated position that the 73 is a required report under DWC rules. The carrier did respond but with denial based on DOS being a duplicate. Our contention is that we are due reimbursement. We have submitted the DWC 73 and are therefore due a reimbursement of $15.00. Documentation is being enclosed to support our position. Thank you."

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:

None submitted.

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
9-6-06	D19, 18	99080-73	1-3	$15.00
Total Due:				$15.00

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. These services were denied by the Respondent with reason code "D19 and 18 – Duplicate claim/service.

2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment.

3. Per Rule 129.5(i) the MAR for a DWC-73 report is $15.00, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §129.5

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 $15.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

	Elizabeth Pickle, RHIA	June 15, 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.