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: Dr. David Rabbani 7447 Harwin, Suite 190 Houston, TX 77036	MFDR Tracking #: M4-07-4642-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Hartford Underwriters Insurance Rep Box # 27	Date of Injury: Employer Name: Boxer Property Management Inc. Insurance Carrier #: YMJC00332

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Respondent did not submit a position summary but the Table of Disputed Services Rationale states "…Fee Guideline…"

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: The Respondent did not submit a response.

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77036 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01/15/2007	W1	99214	1-2	$9.67
Total Due:				$9.67

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 (c)(1) (A) date of service 01/15/2007 was timely filed and is eligible for review.

1. These services were denied by the Respondent with reason code "W1- WC State fee schedule adjust. Reimbursement according to the Texas Medical Fee Guidelines".

2. The CPT code descriptor for procedure code 99214 requires two of these three components: detailed history, detailed examination, medical decision making of moderate complexity. The Insurance carrier made payment to the

Requestor in the amount of $105.49 ($92.13 x 125% =$115.16 -$105.49= $9.67 balance). The Requestor is due an additional amount of $9.67 per Rule 134.202 (b).

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 additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$9.67** plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

05/24/07

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.