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:	MFDR Tracking #: M4-07-4772-01
Allen Kent, M.D, P.A. 800 12th Avenue #200 Fort Worth, TX 76104	DWC Claim #: Injured Employee:
Respondent Name and Box #: Hartford Underwriters Insurance Rep Box #: 27	Date of Injury: Employer Name: AES INDUSTRIES Insurance Carrier #: YKX 06807

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, "Insurance company did not pay correct allowable for provided services."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not submit a response to the DWC-60.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01/08/07	W1, W4	99213 ($59.31 x 125% - $65.58)	1-3	$8.56
Total Due:				$8.56

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 "W1 – WC State Fee Sched adjust. Reimbursement according to the Texas Medical Fee Guidelines" and "W4 – No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. This bill was previously paid."

2. Per Rule 134.202(c)(1) reimbursement for CPT code 99213 is $74.14, Respondent paid $65.58. Additional reimbursement in the amount of $8.56 is recommended.

3. Per review of Box 32 on CMS-1500, zip code 76104 is located in Tarrant County.

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 $8.56 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		07/03/07
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.