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:	MFDR Tracking #:	M4-07-4904-01
Imaging Center Partner dba SW Diagnostic Imaging 8230 Walnut Hill Ln Ste 100 Dallas, TX 75231-4472	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #:	Date of Injury:	
American Home Assurance Co Rep Box #: 19	Employer Name:	ALLIED WASTE INDUSTRIES INC
	Insurance Carrier #:	710274554

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, "AIG Claims Services underpaid CPT code 72148. The TWCC reimbursement equals 125% of the then current Medicare RBRVS. We should have been reimbursed $645.58. We were only paid $487.45. We mailed an appeal for an additional $158.13 on 3/9/07 but our appeal was denied on 3/13/07."

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: "Carrier challenges whether the charges are consistent with applicable fee guidelines. Carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75231 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
02/05/07	1(42)	72148-TC ($516.46 x 125%)	1, 2	$158.13
Total Due:				$158.13

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.

1. These services were denied by the Respondent with reason code "1 – (42) Charges exceed our fee schedule or maximum allowable amount."

2. Per Rule 134.202(c)(1) reimbursement for CPT code 72148 is $645.58, Respondent paid $487.45. Additional reimbursement in the amount of $158.13 is recommended.

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 $158.13 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05/18/07
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.