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: Comprehensive Pain Management 5734 Spohn Drive Corpus Christi, Texas 78414	MFDR Tracking #: M4-07-5127-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: MARYLAND INSURANCE CO BOX 19	Date of Injury: Employer Name: COMMERCIAL DOOR CO OF DALLAS Insurance Carrier #: 000913000085WC01

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Rationale: Physician saw the patient for an office visit for his compensable injury. According to TWC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury…"

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 provider has billed $115.00 for CPT code 99213. Carrier paid $52.39 and asserts that the provider is not due any additional payment…Per the EOBs, carrier paid the proper amount per the fee schedule guidelines for this provider."

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78414 is located in Nueces County.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
9-22-06	F/F	99213 ($61.63 - $52.39 reimbursed by the carrier)	1, 2	$9.24
Total Due:				$9.24

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 initially denied by the Respondent with reason code "F-The reimbursement has been calculated according to the fee schedule guidelines for the provider." Upon reconsideration the denial reason was the same.

2. The Respondent has not reimbursed appropriately. Recommend reimbursement per Rule 134.202(c)(1). The Respondent will be billed for violating this rule.

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 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 $9.24 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

	Donna D. Auby	5-23-07
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.