



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:  SURGICAL AND DIAGNOSTIC CTR STE 100 729 W BEDFORD EULESS RD HURST TX 76053-3939	MFDR Tracking #:	M4-07-5450-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #:  LM INSURANCE CORP BOX 28	Date of Injury:	
	Employer Name:	UNITED PARCEL SERVICE INC
	Insurance Carrier #:	949870483

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "In reviewing this fee dispute the date of service 10-02-06 that was not paid correctly...On our claim, there are several line items for implants that were used for this surgery and Liberty Mutual paid for all but one implant..."

Principle Documentation:

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

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No position summary was received from the Respondent.

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-02-06	150-X901	L8699	1, 2	\$0.00
<b>Total Due:</b>				\$0.00

### 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, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code “150-X901-Documentation does not support the level of service billed.”
2. The Requestor did not provide documentation regarding the SN Endobutton PAC to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d)  
 28 Texas Administrative Code Sec. §133.307, §134.1

**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 not entitled to reimbursement for the services involved in this dispute.

**DECISION:**

Donna 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.**