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: Texas Imaging & Diagnostic Center 3840 W. NorthWest Hwy. # 400 Dallas, TX 75220	MFDR Tracking #:	M4-07-5815-01 Previous# M4-05-A740-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: Security Insurance Co. of Hartford Rep Box # 11	Date of Injury:	
	Employer Name:	Sterilite Corp.
	Insurance Carrier #:	290029247600

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: States in part "…The carrier has denied our claim stating that the procedures were not related to the compensable injury; however the treating doctor Dr. Vaughn, M.D. felt it to be related to the on the job injury sustained on ___; therefore we are asking to be reimbursed per the TWCC 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: Requestor 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 75220 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10/06/2004	R	62284 ($256.59 x 125%)	1-2	$320.74
Total Due:				$320.74

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 (d)(1) date of service 10/06/2004 was timely filed and is eligible for review.
The Requestor withdrew CPT codes 72132,76375,72265,76005 for the date of service 10/06/2004.

1. These services were denied by the Respondent with reason code "R-Extent of Injury".

2. CPT code 62284 for date of service 10/06/2006 was denied with "R". The dispute is over a Lumbar Disc Displacement. According to the DWC agreement dated 03/24/2005 signed by the parties, carrier accepts Lumbar

Disc Injury (Herniation) @ L4-5. The Requestor billed diagnosis codes 722.10-Lumabr Disc Displacement & 724.2-Lumbago on the CMS-1500. Therefore per Rule 134.202(c) (1) reimbursement in the amount of $320.74 ($256.59 x 125%) 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
28 Texas Administrative Code Sec. §133.307

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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$320.74** plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

06/01/2007

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.