Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address: Jerrod Edwards, D. C. 2810 South Cooper Street Arlington, TX 76015	MDR Tracking No.: M4-07-6723-01 Previous Tracking No.: M4-06-6594-01 Claim No.: Injured Employee's Name:
Respondent's Name: Hartford Underwriters Insurance, Box 27	Date of Injury: Employer's Name: Motivating Graphics III Inc. Insurance Carrier's No.: YPU00238C

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: None submitted.

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs
4. DD notice

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received from the Respondent.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
4-7-06	W1/W1	99199-Medical Records (28 pages x $.50)	1, 2	$14.00
TOTAL DUE				$14.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. This service was denied as "W1-WC State Fee Schedule Adjustment. The Prod Code submitted is not the proper code for these services. Please resubmit with the proper code." Per the 2002 MFG CPT Code 99199 is defined as "Unlisted special service, procedure or report."

2. Per Rule 133.2(c) the carrier shall reimburse the reasonable copying charge for records provided to designated doctors, or a doctor performing a required medical examination." Per Rule 133.106(f): "The commission considers fair and reasonable for each submitted required report or record under any section of this title:" (3) Copies of reports or clinical notes - $.50 per page;" On 4-7-06 the Treating Doctor sent copies of medical records to the Designated Doctor for evaluation. The Order to send these records was dated 3-29-06. Reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. §133.106
28 Texas Administrative Code Sec. §133.2
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION DECISION AND 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 in the amount of **$14.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

		7-20-07
Authorized Signature	Typed Name	Date of Order

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.