Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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:

Memorial Therapeutic Products
8200 Wednesbury Suite 475
Houston, TX 77074

TDI/DWC RECEIVED
FEB 14 2008
MEDICAL DISPUTE RESOLUTION

MFDR Tracking #: M4-06-3588-01

Inj

Respondent Name and Box #:

Metropolitan Transit Authority
Box #: 19

Ins

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary, as taken from the Table of Disputed Services states in part, "...Reimbursement was not made based on ins. Carrier fair and reasonable..."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $63.55
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "...Self-insured has issued a fair and reasonable reimbursement for this product. No additional reimbursement is owed..."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	HCPCS Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11/03/05	E0215-NU($88.55=MAR-$25.00	W10, W4	1-2	$63.55
Total Due:				$63.55

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code:
   - W10 – No maximum allowable defined by fee guidelines. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration."

[redacted]

2. The Respondent paid $25.00 for HCPCS code E0215. Per Rule 134.202(c)(2), $88.55($70.84 x 125%) is the MAR: therefore, additional reimbursement is recommended.

A System Monitoring and Oversight referral will be made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 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 $63.55 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

[redacted]	[redacted]	2/13/08
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

[redacted] [redacted]