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: Southwest Center Medical 7125 Marvin D. Love #107 Dallas, TX 75203	MFDR Tracking #: M4-08-3508-01 DWC Clai[redacted] Injured Emplo[redacted] Date of Inj[redacted]
Respondent Name and Box #: American Zurich Insurance Rep. Box #: 19	Employer Na[redacted] Insurance Carrie[redacted]

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary listed on the Table of Disputed Services: "Carrier failed to pay after CCH D&O Carrier failed to pay or respond after request for reconsideration."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $76.94
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...The provider urges a determination of a medical dispute predicated on its understanding of an administrative decision presumed to be final. It does not provide a copy of any such decision. Carrier contends its denial is proper at this time. Should further evidence develop the carrier will consider same..."

Principle Documentation:

1. DWC-to Response

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
02/08/07	CPT Code 99213 ($61.55 x 125%)	W11	1, 2, 3, 5	$76.94
02/08/07	99080-73	W11	1, 2, 4	$15.00
Total Due:				$91.94

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 "W11 – Entitlement to benefits. Not finally adjudicated."

2. According to a contested case hearing held on May 9, 2007, the compensable injury of June 22, 2006 extends to the right carpal tunnel syndrome and bilateral wrist tenosynovitis. The compensable injury of June 22, 2006 does not extend to left carpal tunnel syndrome, bilateral median neuritis, bilateral elbow strain, bilateral ulnar entrapment, and right shoulder strain. Therefore, the disputed date of service will be review in accordance with Division rules.
3. Per Division Rule at 28 Texas Administrative Code Section 134.202(c)(1) reimbursement for CPT Code 99213 is recommended.
4. Per Division Rule at 28 Texas Administrative Code Section 129.5 reimbursement for CPT Code 99080-73 is recommended.
5. Per review of Box 32 on CMS-1500, zip code75237 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

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. 129.5, 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $91.64 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

[redacted]	[redacted]	03/27/08
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.