



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Southeast Health Services P. O. Box 170336 Dallas, Texas 75217	MDR Tracking No.: M5-06-0454-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Zurich American Insurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

- Principle Documentation:
1. DWC-60
  2. Explanation of Benefits
  3. CMS 1500's
  4. Medical Documentation

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

- Principle Documentation:
1. DWC-60
  2. Explanation of Benefits
  3. Medical documentation
- Position Summary states, "All fees were paid according to MFG. The provider's requests for additional reimburse are baseless."

### 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)
11-16-04	F	CPT code 93799	1	\$00.00
<b>TOTAL DUE</b>				<b>\$00.00</b>

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

1. The requestor billed \$122.00 for CPT code 93799 on 11-16-04. The insurance company paid \$91.50 and sent proof of payment with a copy of Check Number 1876179880. Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOB's or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend no additional reimbursement.

Regarding CPT code 97113 on 10-26-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recommend reimbursement of \$84.98 (\$42.49 X 2 units).

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

28 Texas Administrative Code Sec. § 413.011(a-d)  
28 Texas Administrative Code Sec. § 134.1, 133.304 and 133.307(g)(2) and (3)

**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 \$84.98.

Ordered by:

Donna Auby

11-22-05

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.**