



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:  <p style="text-align: center;">Workers Comp Health Clinic          5425 South Padre Island Drive, Suite 175          Corpus Christi, TX 78411</p>	MFDR Tracking #: M5-08-0016-01 (current MDR #) M4-03-5075-01 (former MDR #)
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  <p style="text-align: center;">American Home Assurance Company          Rep Box # 19</p>	Date of Injury:
	Employer Name:
	Insurance Carrier #:

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

Requestor's Position Summary: Per the Table of Disputed Services "Our office has not received an explanation or payment for this date of service within the 45 day limit and no response received for reconsideration request within the 21 day deadline...Documentation of procedure was submitted for this date of service with original claim and the request for reconsideration."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$2,288.00 \*
3. CMS 1500(s)
4. EOB(s)

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

Respondent's Position Summary: No position summary was submitted by the Respondent

Principle Documentation: No response submitted by the Respondent

### PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Ordered
03-21-02 to 04-05-02	97113	NO EOB	1 & 2	\$1,456.00
04-08-02	97113	N/241	3	\$00.00
<b>Total Due</b>				<b>\$1,456.00</b>

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.201 titled, *1996 Medical Fee Guideline effective April 1, 1996*, sets out the reimbursement guidelines.

\* Note: Dates of service 05-09-02, 05-10-02 and 05-14-02 for CPT code 97113 have been dismissed per Rule 133.308(r)(7)(8) and (11) and will not be part of the review nor will the amount of \$624.00 in dispute for these dates be included in the review.

1. Neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(b) the Requestor submitted convincing evidence of the carrier receipt of the providers request for EOBs. The review will be per the 1996 Medical Fee Guideline.
2. Reimbursement is recommended in the following amount **\$1,456.00 (1 unit @ \$52.00 x 4 units billed x 7 DOS)**.
3. This service was denied with denial reason "N/241" (Not documented). The Requestor did not submit documentation for review by MFDR. No reimbursement is recommended.

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

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311  
 28 Texas Administrative Code Sec. §134.1, §133.307 and §133.308  
 Subchapter G, Chapter 2001, Texas Government Code  
 1996 Medical Fee Guideline

**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 \$1,456.00 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

**ORDER:**

11-08-2007

\_\_\_\_\_  
 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.**