



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: STEVEN S. CALLAHAN, PH. D. & ASSOCIATES 4101 GREENBRIAR, SUITE 115 HOUSTON, TX 77098	MFDR Tracking #: M5-09-0001-01 Previous #: M4-06-3720-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: PACIFIC EMPLOYERS INSURANCE CO Box 15	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The documents clearly show the carrier's failure to abide by reimbursement guide lines."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$418.04
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary (Table of Disputed Services): "Extent of injury. CRCC received bill on 6-6-05. EOB was printed on 7-6-05 and mailed."

Principle Documentation:

1. Response to DWC 60
2. EOBs

PART IV: SUMMARY OF FINDINGS

Dates of Service	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
2-2-05	90808	R, Unnecessary Treatment/service (report attached)	1, 2, 3	\$178.54
2-9-05	90806		1, 2, 3	\$119.75
2-16-05	90806		1, 2, 3	\$119.75
Total Due:				\$418.04

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

1. Per the determination at a Benefit Revidw Conference on 10-08-03 the claimant's injury extends to both diagnoses of the left knee. The Requestor is billing with the diagnosis of 836.0 – Tear of Medial Cartilage or Meniscus of Knee and 309.89-Adjustment Reaction. These services are compensable. The Respondent was given an opportunity to reaudit the CMS 1500's. No response was received.
2. Per review of Box 32 on CMS-1500, zip code 77469 is located in Fort Bend County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.
3. The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. Per Rule 134.202(d)(2) the amount due the Requestor for these items is \$418.04.

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 Sections 133.308 eff. 1-2-03, 134.1 eff. 5-16-02, 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, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$650.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to additional reimbursement in the amount of \$418.04. The Division hereby **ORDERS** the Carrier to remit to the Requestor this amount plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

	Donna D. Auby	10-29-08
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.