Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR DWAYNE O WILLIAMS
17510 W GRAND PKWY SOUTH NO 180
SUGARLAND TX 77479

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-2136-01

MFDR Date Received
February 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No written position submitted with DWC060.

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Texas Mutual reviewed the requestor's E&M documentation and found the exam consisted of the following body areas-(1) head, ears, nose and throat; (2) neck and back; (3) respiratory, "Chest is clear" (4) cardiac, "heart is regular in rhythm", (5) abdomen; (6) upper extremities; and (7) lower extremities. Under the 1995 E&M Guidelines that equates to an expanded problem focused exam."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2011	Professional Services	$250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC – 150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED.
   - 890 – DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.
   - CAC – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Did the requestor's documentation support level of service billed?
2. Did the respondent support the denial of E&M code?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(2)((M) "a copy of all applicable medical records related to the dates of service in dispute." Review of the submitted documentation finds the requestor provided only copies of the MRI report dated 9/2/2011 and an Explanation of Benefits dated 07/06/2011, 11/08/2011 and 12/30/2011. No copy of the original bill or physician notes from the disputed date of service was included with the request for medical fee dispute. Therefore, the division finds the request for medical fee dispute does not meet provision of TAC 133.307.
2. The carrier submitted an attachment that is dated June 3, 2011. As the DWC060, and Explanation of Benefits show the date of service to be June 2, 2011 this documentation could not be linked to service in dispute.
3. As no documentation was presented to support services provided on date of service listed on the Explanation of Benefits and the DWC060, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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