Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address: MRI Central 9840 N. Central Expy, Ste 254 Dallas, TX 75231	MDR Tracking No.: M4-05-4113-01 Claim No.: Injured Employee's Name:
Respondent's Name: Fairmont Insurance Co. Rep Box: 28	Date of Injury: Employer's Name: CC Young Memorial Home Insurance Carrier's No.: A99174658

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary from the Table of Disputed Services states, "Prior to services being rendered, carrier preauthorized services then denied for no preauthorization. Requested reconsideration 04-19-04 and carrier failed to respond within 21 days as required. On 08-09-04, carrier retrospectively reviewed charges for medical necessity and rejected our bill in violation of Rule 133.301(a)."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a response to MDR.

Principle Documentation: 1. N/A

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)
02-06-04	240, 283/V,283	72148-MRI	1-3	$747.91
TOTAL DUE				$747.91

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

1. The Requestor billed CPT code 72148 for DOS 02-06-04. The Respondent denied the service with, "240-Pre-Authorization not obtained and 283-Based on a Peer Review, payment is denied because the treatment(s)/service(s) is medically unreasonable/unnecessary."

2. The Requestor obtained preauthorization for CPT code 72148 per Rule 134.600(h)(7). The service was preauthorized under preauthorization #124274.

3. Per Rule 133.301(a) in effect at the time services were rendered, the insurance carrier may not retrospectively review the medical necessity of a medical bill for treatments/services that the health care provider has obtained preauthorization. Therefore, per the 2002 MFG reimbursement is recommended in the amount of $747.91. The Respondent will be billed for the use of an inappropriate denial and a referral to Legal & Compliance will be made by MDR.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.600
28 Texas Administrative Code Sec. §133.301

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 **$747.91.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Patricia Rodriguez	10-27-06
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.