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: Dr. Stephen Esses 6560 Fannin #1900 Houston, TX 77030	MDR Tracking No.:	M4-05-6667-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: Texas Mutual Insurance Co. Rep. Box # 54	Date of Injury:	
	Employer's Name:	Dawson Industries Inc.
	Insurance Carrier's No.:	9600000164820

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "Rec'd Auth for surgery and now Ins. Carrier is stating it is not related to comp. injury when we verified benefits. Adj stated comp. injury was low back."

Principle Documentation:
1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits (EOBs)
4. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a position summary.

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)
3-24-04	No EOB	63030	1-6	$1,128.62
TOTAL DUE				$1,128.62

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. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 11-15-04.

2. Based on Division Rule 133.307(d)(1-2), the only date of service eligible for review is 3-24-04.

3. The Requestor complied with Rule 133.304 by submitting medical bills for reconsideration. The Respondent did not dispute that they did not receive these medical bills. Per Rule 133.307(e)(2)(b), the Requestor submitted convincing evidence of carrier's receipt of the Requestor's request for an EOB; therefore, the disputed service will be reviewed in accordance with the Division's *Medical Fee Guideline.*

4. A review of Division records indicates that the insurance carrier accepted the low back injury as compensable.

5. The insurance carrier gave preauthorization approval for "23 hour observation for L5/S1 right discectomy."

6. Per CMS-1500, the zip code 77023 is located in Harris County. The MFG MAR for CPT code 63030 in Harris County is $1,128.62, this amount is recommended.

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. §133.307

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 **$1,128.62.** 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:

	Elizabeth Pickle, RHIA	April 30, 2007
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.