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: Mark Hackbarth, MD 700 Olympic Plaza Circle #850 Tyler, TX 75701	MDR Tracking No.: M4-05-A170-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Casualty Company Rep Box # 47	Date of Injury: Employer's Name: Davita Inc. Insurance Carrier's No.: 3A807294

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states they requested 2 units in their faxed pre-auth letter to the carrier.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's
5. Pre-Auth Letter
6. Carriers Pre-Auth Letter

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent states that they feel no additional reimbursement is due.

Principle Documentation: 1. TWCC-60 Response

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)
05/05/05	A	63650-59	1	$00.00
TOTAL DUE				$00.00

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

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

1. CPT Code 63650-59 for date of service 05/05/05 denied with A (Preauthorization required but not requested). Per Rule 134.600 the healthcare provider requested pre-authorization for CPT Code 63650 twice, however did not attach a modifier on the same but subsequent procedure , nor did the provider give a description of the procedure. The insurance carrier only preauthorized one unit. The insurance carrier also stated that if there was any confusion on the part of the requestor they could have called the carrier and requested clarification but instead they performed the 2nd procedure without preauthorization. Therefore it is the conclusion of MDR that no additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202

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 not** entitled to additional reimbursement.

Ordered by:

		03/23/06
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.