Texas Department of Insurance, Division of Workers' Compensation
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: Spinecare, LLP 5734 Spohn Dr. Ste. B. Corpus Christi, TX 78414 - 4116	MFDR Tracking #: M4-07-2750-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box 54	Date of Injury: Employer Name: ASTON MARBLE & GRANITE LLC Insurance Carrier #: 99G0000442999

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): Authorization was obtained prior to services rendered. See Auth letter (Exhibit #3). Monitored anesthesia care is separately reimbursable per Medicare. (See Exhibit #4)"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of Preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Even though the provider listed MAC in its requests TM is under no obligation, according to Rule 134.600, to render a decision or to notify the provider that it will not review a request for MAC. All system participants, TM asserts, are responsible for proper application of the pertinent rules. TM has had multiple requests for preauthorization from this requestor and TM believes that requestor is very well acquainted with the requirements of preauthorization at the time of its request."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78414 is located in county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
9-21-06	244, 50, W4, 891	01992-AA-QS (5.47 units x 47.37 – conversion factor)	1, 2, 3, 4	$259.17
Total Due:				$259.17

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

1. These services were denied by the Respondent with reason code "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer," "244-unnecessary medical – Documentation does not support medical necessity for monitored IV sedation or general anesthesia during this injection procedure," "W-4-No additional reimbursement allowed after review of appeal/reconsideration," and "891-The insurance company is reducing or denying payment after reconsideration."

2. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 8-28-06 for "TF-LESI @L4-L5" (including CPT code 01992). The Respondent denied these sessions for unnecessary medical treatment based on a peer review. Per Rule 134.600 (c)(1)(B) – "The carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care."

3. Rule 134.600(j)(3) states "Carrier certification, or agreement to pay, subjects the carrier to liability in accordance with subsection (b)(2) of this section even if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury."

4. Per Rule 134.202(c)(1) anesthesia is reimbursed as: Number of units x 47.37 (conversion factor) = MAR. Reimbursement of $259.17 is recommended. (5.47 units x 47.37).

A Legal and Compliance referral will be made for inappropriate denial of the preauthorized service per Rule Per Rule 134.600 (c)(1)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION DECISION AND/OR 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $259.17 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Donna D. Auby	5-23-07

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.