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

Nestor Martinez, D.C. 6660 Airline Dr. Houston, TX 77076	MFDR Tracking #: M4-07-3694-01 DWC Claim #: Injured Employee:
Respondent Name: ZURICH AMERICAN INSURANCE CO Box 19	Date of Injury: Employer Name: AMERICAN RESIDENTIAL SERVICES Insurance Carrier #: 2230126218

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Our facility had pre-authorization for these services."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The requestor alleges that all services were preauthorized, but has not submitted evidence of such. Carrier requests that the provider submit proof the preauthorization [sic] and Carrier will review same."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Per Box 32 on CMS-1500 county where services were rendered: Harris

Date(s) of Service	Denial Code(s)	CPT Code(s) and MAR	Part V Reference	Amount Due
8-3-06 – 8-10-06	18, 24, 151, 213	97110 (MAR = $35.85 x 3 units)	1, 2, 3	$107.55
8-3-06 – 8-10-06	18, 24, 151, 213	97140 (MAR = $33.33 x 6 units)	1, 2, 3	$199.98
Total Due:				$307.53

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 "151-Payment adjusted because the payer deems the information submitted does not support this many services," "213-The charge exceeds the scheduled value and/or parameters that would appear reasonable," "18-Duplicate claim/service," and "224-Duplicate Charge."

2. Per Rule 134.600 (h), the Requestor provided a copy of a preauthorization letter dated 8-02-06 for 6 visits of PT Lumbar. The Respondent denied these sessions for unnecessary medical treatment. Rule 134.600(c)(1)(B) states that 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. A referral has been made to Legal and Compliance for violation of Rule 133.301 (a).

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 additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $307.53 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

	Donna Auby	5-9-07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.