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 Name and Address: Nestor Martinez, D.C. 6660 Airline Dr. Houston, Texas 77076	MFDR Tracking #: M4-07-4006-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Zurich American Insurance Co. REP BOX #: 19	Date of Injury: Employer Name: Millennium Rail Inc. Insurance Carrier #: 2230119897

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Our facility had pre-authorization for these services."

Principle Documentation:

1. DWC 60 package
2. CMS 1500
3. Medical Records
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "In immediate case the carrier disputes that the provider submitted any claim-specific substantive explanation with its request for reconsideration. It appears from the MDR submission that all that the provider submitted was the original bill(s). Accordingly. The carrier contends that the request was incomplete and fails to satisfy the prerequisite for medical dispute resolution. This matter is not ripe for review and should be dismissed pursuant to 28 TAC 133.307(m)(3)."

Principle Documentation:

1. Position Summary
2. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
08/09/06-08/11/06	No EOB	99212 x 3 units/DOS	1	$148.32
08/09/06-08/11/06	No EOB	97545-WH x 3 units(6hrs)	2	$307.20
08/09/06-08/11/06	No EOB	97546-WH x 15 hrs	3	$768.00
Total Due:				$1,223.52

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. This dispute is related to CPT code 99212 for date of service 08/09/06-08/11/06. Neither party submitted copies of EOB's, however per Rule 133.307(c)(2)(B) the Requestor submitted proof of a request for EOB's. Therefore, this dispute will be reviewed according to the Medical Fee Guideline. Reimbursement is recommended in the amount of **$148.32** per Rule 134.202(c)(1) **($39.55 X 125% = $49.44 x 3 DOS)**.

2. This dispute is related to CPT code 97545-WH x 3 units for dates of service 08/09/06-08/11/06. Neither party submitted copies of EOB's, however per Rule 133.307(c)(2)(B) the Requestor submitted proof of a request for EOB's. Therefore, the disputed service will be reviewed according to the Medical Fee Guideline. Requestor received preauthorization # 060802-064174 on 08/02/06 for work hardening. Per Rule 134.202(e)(5)(A)(ii) reimbursement recommended in the amount of **$307.20 ($64.00/ hour x 80%=$51.20 x 2 hours = $102.40 x 3 DOS).**

3. This dispute is related to CPT code 97546-WH x 15 hrs for dates of service 08/09/06-08/11/06. Neither party submitted copies of EOB's, however per Rule 133.307(c)(2)(B) the Requestor submitted proof of a request for EOB's. Therefore, the disputed service will be reviewed according to the Medical Fee Guideline. Requestor received Preauthorization # 060802-064174 on 08/02/06 for work hardening. In addition, per Rule 134.202(e)(5)(C)(ii) reimbursement is recommended in the amount of **$768.00 ($64.00/ hour x 80%=51.20 x 15** hrs**).**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §133.307

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 **$**1,223.52 plus accrued interest, due within 30 days of receipt of this Order.

Order:

05/29/07

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.