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: Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231-3444	MFDR Tracking #: M4-07-4340-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO BOX 54	Date of Injury: Employer Name: JACK OF ALL TRADES PERSONNEL Insurance Carrier #: 99G0000444757

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…It is our position that Texas Mutual Insurance should have paid for these services due to the fact that they were preauthorized and the services were related to the compensable work injury…"

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Texas Mutual's position at this time is that …depression disorder is not related to the compensable injury sustained ___. Until the extent of injury issue has been fully resolved, Texas Mutual requests the Department to stay this dispute."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76705 is located in McLennan county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
4-6-06	47, W4, 246, 891, W2, 245	90801	1, 2, 5	$183.81
5-9-06	47, W4, 246, 891, W2, 245	96102 ($51.28 = x 3 units)	1, 2, 3, 5	$153.83
6-23-06	47, W4, 246, 891, W2, 245	90806	1, 2, 4, 5	$118.95
Total Due:				$456.59

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 "47-This diagnosis is not covered, missing or is invalid," "W-4-No additional reimbursement allowed after review of appeal/reconsideration," "246-The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place," "891-The insurance company is reducing or denying payment after reconsideration," "W-2-Workers Compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment," and "245-The carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place."

2. These services were billed with Diagnosis Code 722.2 - DISPLCMT INTERVERT DISC SITE UNS W/O MYELOPA. This is a covered, valid Diagnosis Code.

3. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter (#1698185) dated 6-19-06 for Psychological Testing.

4. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter (#1680876) dated 4-26-06 for individual Psychotherapy.

5. A Contested Case Hearing on 9-26-06 determined that the injured worker sustained a compensable injury, including a low back injury, on ___. Per PLN 11's the insurance carrier disputes cervical s/s, Dorsal s/s, RT WRI St S/S, Major depression, bilateral neuroforaminal stenosis and narrowing L4-S1. The doctor billed with Diagnosis Code 722.2 – Disc Displacement NOS. Therefore, treatment was to the compensable body part. Recommend reimbursement per Rule 134.202(c)(1).

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 $456.59 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

	Donna Auby	5-23-07
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.