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:	MFDR Tracking #: M4-07-5038-01
Ben-Brig Supnet, M. D. %Spinecare UP 5734 Spohn Dr. Ste B Corpus Christi, TX 78414	DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box 54	Date of Injury: Employer Name: GULF COAST MARINE INC Insurance Carrier #: 99G0000457260

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)."

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

Position statement submitted by Texas Mutual does not address the disputed issues.

Principle Documentation:

1. Response to DWC 60
2. EOB(s)

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
9-21-06	244, 50	01992-AA-QA (6.2 units x $47.37- conversion factor)	1, 2, 3, 4	$293.69
Total Due:				$293.69

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," and "244-unnecessary medical."

2. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 8-07-06 for "2 level lumbar transforaminal ESI" (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 $293.69 is recommended. (6.2 units x 47.37).

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service 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. 28 Texas Administrative Code Sec. 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 $293.69 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

	Donna D. 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.