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: Nestor Martinez, DC 6660 Airline Dr. Houston, TX 77076	MFDR Tracking #: M4-07-5500-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: New Hampshire Insurance Co. Box 19	Date of Injury: Employer Name: TL Nexlevel Co LLC Insurance Carrier #: 709373422

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(s)
3. EOB(s)
4. Copy of Preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier will review these bills to determine what amount, if any, should be paid to Provider."

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77076 is located in Harriscounty.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
11-27-06, 11-30-06	No EOBs	99212 ($49.44 x 2 DOS)	1	$98.88
11-27-06, 11-30-06	No EOBs	97110 ($35.86 x 8 units)	1, 2	$286.88
11-27-06, 11-30-06	No EOBs	97140 ($33.33 x 4 units)	1, 2	$133.32
11-27-06, 11-30-06	No EOBs	97112 ($37.16 x 2 units)	1, 2	$74.32
Total Due:				$593.40

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. Neither the Respondent nor the Requestor provided EOBs for these services. The Requestor submitted convincing evidence of carrier receipt for "Request for Reconsideration EOBs" in accordance with 133.307 (e)(2)(B). This review will be according to Rule 134.202.

2. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 11-08-06 for six sessions of physical therapy.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §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 $593.40 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		5-29-07
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.