Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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, D.C. 6660 Airline Drive Houston, TX 77076	MFDR Tracking #: M4-07-6367-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO BOX 54	Date of Injury: Employer Name: ASSOCIATED MARINE & INDUSTRIAL Insurance Carrier #: 99G0000470595

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)
4. Copy of Preauthorization Letter

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Per verbal notification given 11-13-06; notified Angela that the session/visit is limited to no more than an hour, no more than 4 CPT codes, and no more than 45 minutes of cumulative timed codes…Texas Mutual believes its payment is consistent with the approval given, Rule 134.202, treatment protocols, and CMS LCD policy, therefore, no further reimbursement is due."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
11-27-06 – 12-7-06	62, 930	97140 ($33.33 x 4 units)	1, 2	$133.32
Total Due:				$133.32

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 "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," and "930-Pre-authorization required, reimbursement denied."

2. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of a preauthorization letter dated 11-13-06 for (12) sessions of CPT codes 97110, 97140 and 97112. Per Rule 134.600 the Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization.

3. Per review of Box 32 on CMS-1500, zip code 77076 is located in Harris County.

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. §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 $133.32 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

8-1-07

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.