



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: Health Care Provider Injured Employee Insurance Carrier

Requestor's Name and Address:

Michele Zamora LPC
6660 Airline Drive
Houston TX 77076

MDR Tracking No.:

M5-06-0854-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

Rep Box #29

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. DWC-60 packet

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. The Carrier did not respond to the Provider's request for Medical Dispute Resolution.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | Denial Code | CPT Code(s) or Description | Part V Reference | Additional Amount Due (if any) |
|---------------------|-------------|----------------------------|------------------|--------------------------------|
| 11-08-05 & 11-09-05 | W9 | 97799-CP | 1 | \$-0- |
| 11-10-05 & 11-11-05 | W9 | 97799-CP | 2 | \$1,400.00 |
| Total Due | | | | \$1,400.00 |

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- On 11/07/05, the Provider submitted a request for pre-authorization to the Carrier for 20 sessions of chronic pain management. On 11/10/05, the Carrier approved 10 sessions for dates of service 11/10/05 through 12/10/05 (pre-auth # ALVA11072005001). Pursuant to Rule 134.600(f)(4)(5)(B), the Provider did not have pre-authorization for dates of service 11/08/05 and 11/09/05 as these two dates of service were outside the timeframes of the pre-authorization. Therefore, reimbursement is not recommended.
- On 11-10-05, the carrier issued a preauthorization approval letter (#ALVA11072005001) for 10 visits of chronic pain management. On 11-10-05 and 11-11-05, the requestor provided these services. The carrier's EOB denied reimbursement as unnecessary medical treatment with peer review. Per Rule 133.301(a), an insurance carrier cannot retrospectively deny a medical bill for treatment or services for which the healthcare provider has obtained preauthorization under rule 134.600(h). Recommend reimbursement of \$125.00 per hour x 80% for non-CARF x 7 hours = \$700.00 x 2 days (14 hrs.) = \$1,400.00 plus interest.

A Compliance & Regulation referral will be made against the carrier for inappropriate denial.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. § 413.011(a-d)
28 Texas Administrative Code Sec. §134.202, 133.301(a), 134.600(e), 134.600(f)(4)(5)(B), 133.600(h)

PART VII: DIVISION DECISION AND 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 additional reimbursement **in the amount of \$1,400.00 plus interest.**

Ordered by:

4/19/06

Authorized Signature

Typed Name

Date of Order

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.