Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	MDR Tracking No.: M5-06-0996-01
Michele Zamora LPC 6660 Airline Drive Houston TX 77076	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. Requestor's position statement – None submitted with DWC-60 package

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. None submitted.

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)
11-14-05 to 11-23-05	W9	97799-CP	1	$4,900.00
TOTAL DUE				$4,900.00

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

1. On 11-10-05, the carrier issued a preauthorization approval letter (#ALVA11072005001) for 10 visits of chronic pain management. On 11-14-05 to 11-23-05, requestor provided these services and the carrier denied as unnecessary medical treatment. 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 7 days - $4,900.00.
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)

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 $4,900.00.**

Ordered by:

Authorized Signature	Typed Name	3-29-06 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.