



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: Dr. Richard Adair 963 S. Mason Rd Katy, TX 77494	MDR Tracking No.: M5-06-1867-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: Continental Casualty Company, Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary (Table of Disputed Services) states, "Patient in a lot of pain – prior treatment in...was reimbursed. Patient transferred to our practice as she relocated. Treatment relieves her pain."

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states, "Attached is the completed DWC-60 form Initial Request for Medical Dispute Resolution. Pursuant to Rule 133.307(g), we shall await notification of the appropriate medial dispute resolution."

Principle Documentation:

1. DWC 60 response

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)
3-15-06	38, 45	CPT code 98941	1	\$0.00
Grand Total				\$0.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

In a letter dated 8-15-06 the Requestor withdrew services which were denied for medical necessity. These services will not be a part of this review.

On 8-8-06 the Medical Review Division submitted a Notice to Requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the Requestor's receipt of the Notice.

1. The Respondent denied this service as “38-Denied per insurance, treatment not approved by treating physician 100%,” and “45-Charges exceed your contracted/legislated fee arrangement.” In a telephone call on 8-15-06 the Requestor stated that it has no contract with this Respondent. Per the DWC 53 Dr. Adair was not approved as this injured worker’s Treating Doctor until 4-03-06 per Rule 126.9. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. §126.9
28 Texas Administrative Code Sec. §134.1

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 not entitled to reimbursement.

Finding and Decision by:

	Medical Dispute Officer	10-11-06
_____ 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.