



## 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:  Spinecare, L.L.P. 5734 Spohn Drive, Ste. B Corpus Christi, Texas 78414	MDR Tracking No.: M5-06-1937-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name:  Texas Mutual Insurance Company, Box 54	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 in part, "Rationale: Authorization was obtained prior to services being rendered. See Auth Letter (Exhibit #3) monitored anesthesia care is separately reimbursable per Medicare's reimbursement guidelines. (See Exhibit #4)."

Principle Documentation:

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

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position statement submitted by Texas Mutual does not address the disputed issues.

Principle Documentation: No Documentation was submitted by the Respondent.

### 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)
05-03-06	50, 224	01992-AA-QS	1	\$129.55
Grand Total				\$129.55

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

On 8-15-06 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 "50-These are non-covered services because this is not deemed a "Medical Necessity" by the payer, "244-Unnecessary Medical," and "224-Duplicate charge."
2. Per Rule 134.600 (h), the Requestor provided a copy of a preauthorization letter dated 4-03-06 for 1 unit of CPT code 01992.

- 3. The Respondent denied this service for unnecessary medical treatment. Rule 134.600 (c)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care." These services were voluntarily preauthorized by the Respondent. A Legal and Compliance referral will be made for inappropriate denial of the preauthorized service.
- 4. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code 413.011(a-d), 413.031  
 28 Texas Administrative Code Sec. 134.202, 134.600

**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 \$129.55. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Medical Dispute Officer

10-02-06

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.**