



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: Imaging Center Partnership, dba Southwest Diagnostic Imaging Center 8230 Walnut Hill Lane, Suite 100 Dallas, TX 75231	MDR Tracking No.: M5-07-0258-01 Claim No.: Injured Employee's Name:
Respondent's Name: TEXAS MUTUAL INSURANCE CO, 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, "On 11-25-05, more than two weeks before we performed these services, we called and spoke with the adjustor, Priscilla Griffin. Ms Griffin told us no precertification was required for an initial CT scan. However, Texas Mutual denied our claim, stating pre-authorization was required. Please have Texas Mutual pay our claim."

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.

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)
12-14-05	62, 287, 930	72132-TC	1	\$0.00
Total Due				\$0.00

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

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

CPT codes Q9950 and 76375 were withdrawn by the Requestor in a letter dated December 28, 2006. They will not be a part of this review.

1. This service was denied by the carrier as "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization," "287-This service is denied because the doctor is not on the Texas Approved Doctor's List (ADL) for this date of service," and "930-Pre-authorization required, reimbursement denied."

2. Per Rule 134.600 this service does not require preauthorization.
3. The Requestor is requesting reimbursement for the Technical portion of this service (72132). However, unless this was an emergency or there was a temporary exception, the radiologist must be on the ADL list per Rule 180.20.
4. 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. 134.1, 134.202

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 for the services involved in this dispute.

Ordered by:

Authorized Signature

Typed Name

2-05-07

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.