



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, LLP 5734 SPOHN DR. STE B CORPUS CHRISTI, TX 78414	MDR Tracking No.: M5-07-0283-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: TEXAS MUTUAL INSURANCE CO. REP 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 states in part, "Authorization was obtained prior to services being rendered. See auth letter (Exhibit #3)"

- Principle Documentation:
1. DWC 60 package
 2. EOB's
 3. Pre-Authorization approval
 4. CMS-1500/ Anesthesia Medical Record

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states: No Response given.

- Principle Documentation: 1. DWC 60

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)
07/20/06	CAC-50, W4, 244, 891	01992 –AA QS	1, 2, 3	\$130.87
TOTAL DUE				\$130.87

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, sets out reimbursement guidelines.

1. This dispute relates to procedure 01992; the Respondent used denial codes "CAC-50 – These are non-covered services because this is not deemed a medical necessity by the payer.", "W4 – No additional reimbursement allowed after review of appeal/reconsideration.", "244 – Unnecessary medical." and "891- The insurance company is reducing or denying payment after-reconsideration."
2. The Requestor submitted the request for preauthorization, which included CPT code 01992. The Respondent preauthorized the services stating, "Authorization given for appeal for left sided transforaminal epidural steroid injection at the left L5-S1 to be done @ Spine Care Outpatient Surgery Center to be done within 60 days of authorization (06-22-2006 to 08-22-2006). A MUTUALLY AGREED CHANGE IN THE REQUESTED HEALTH CARE TREATMENTS AND/OR PERIOD OF TIME FOR COMPLETION HAS BEEN ESTABLISHED."

2. Per Rule 134.202(c)(1) reimbursement calculation is as follows:

Time Units=14 minutes ÷ 15 = .93 Units

Base Units= (CPT code 01992)=+ 5 Units

.93 + 5 Units= 5.93 Units

5.93 Units x \$47.37(conversion factor)= \$281.06

Requestor has indicated on the Table of Disputed Services the amount in dispute to be \$130.87. Therefore, according to Rule 134.202(d)(2) reimbursement of \$130.87 is recommended.

A Legal and Compliance referral will be made as the Respondent is in violation of Rule 134.600(c) (1) (B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §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 entitled to additional reimbursement in the amount of \$130.87, plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this order.

Decision and Order by:

01/29/07

Authorized Signature

Typed Name

Date

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.