



Texas Department of Insurance, Division of Workers' Compensation
 Medical Fee Dispute Resolution, MS-48
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: <p style="text-align: center;">SpineCare, LLP 5734 Spohn Drive, Suite B Corpus Christi, Texas 78414</p>	MFDR Tracking #: M5-07-0295-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: <p style="text-align: center;">ST. PAUL FIRE & MARINE INS. CO. REP BOX #: 05</p>	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: Rationale: Authorization was received prior to services being rendered. See Auth (Exhibit #3) [64476], See Auth request (Exhibit #4) [64475]."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Approval Letter
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not include a Position Summary in their DWC 60 response.

Principle Documentation:

1. Response to DWC 60
2. DWC 60/Table of Disputed Services
3. CMS 1500s
4. EOBs
5. Preauthorization Approval Letter
6. Medical Records/Peer Review Reports

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
09/21/06	W9/W9	64475-SG-RT 64476-SG-RT 64475-SG-LT 64476-SG-LT	1 - 4	\$354.93 \$137.48 \$137.48 \$354.93
Total Due:				\$984.82

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

The Division contacted the Respondent’s preauthorization representative at Concentra Health Services, Inc. on 06/04/07 to confirm if preauthorization approval was given for both level L4-L5 and level L5-S1. The Division spoke with Ms. Shawn Daris, Supervisor to June Glover, the representative that authorized services on 09/05/06. Ms. Daris confirmed that preauthorization was in fact given for both level L4-L5 and level L5-S1. Ms. Daris further clarified that the word ‘2nd’ on the preauthorization approval letter referred to the fact that this was the claimant’s 2nd injection.

Preauthorization approval #1773302 was given on 09/05/06 for a 2nd Level Bilateral Lumbar Facet Block Injection at L4-5 and L5-S1 (CPT codes 64475-50 and 64476-50) with a start date of 08/31/06 and an end date of 10/31/06.

Rule 134.600(c)(1)(B), states, “...The carrier is liable for all reasonable and necessary medical costs relating to the health care...listed in subsection (p) or (q) of this section only when the following situations occur...preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care...”

1. This dispute relates to CPT codes 64475-SG-RT & LT and 64476-SG-RT & LT for date of service 09/21/06 initially denied with reason code “W9—Unnecessary medical treatment based on peer review.” Upon reconsideration reimbursement was denied the same.
2. Per review of Box 32 on CMS-1500, zip code 78414 is located in Nueces County.
3. Per Rule 134.202(b) and (c)(1), reimbursement in the amount of \$984.82 is recommended.
 - CPT code 64475-SG-RT = \$354.93 (\$283.94 x 125% = \$354.93)
 - CPT code 64476-SG-RT = \$137.48 (\$109.98 x 125% = \$137.48)
 - CPT code 64475-SG-LT = \$354.93 (\$283.94 x 125% = \$354.93)
 - CPT code 64476-SG-LT = \$137.49 (\$109.98 x 125% = \$137.48)
 - TOTAL: \$984.82

4. A referral was made to Legal and Compliance against the Respondent for violation of Rule 134.600(c)(1)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$984.82 plus accrued interest, due within 30 days of receipt of this Order.

DECISION AND ORDER:

06/08/07

Authorized Signature

Medical Fee Dispute Resolution Officer

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.