Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

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:	MDR Tracking No.: M5-07-0352-01
David M. Griffith, D.C. 800 Dolorosa #400 San Antonio, TX 78207	Claim No.:
	Injured Employee's Name:
Respondent's Name:	Date of Injury:
TEXAS MUTUAL INSURANCE CO, BOX 54	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, "Compensable injury."

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)
3-15-06	47, 246, 891, 930	97035	1	$14.59
1-12-06 – 3-29-06	47, 246, 891, 930	97110 ($33.46 x 51 units)	1	$1,706.46
1-12-06 – 3-29-06	47, 246, 891, 930	97112 ($31.79< MAR x 14 units)	1	$445.06
3-15-06	47, 246, 891	97032	2	$18.94
3-15-06	B18, 47, 246, 891, 893	97010	3	$0.00
3-2-06	248, 891	99080-73	4	$15.00
	Total Due			$2,200.05

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

In a letter dated 1-12-07 the Requestor withdrew the office visits (CPT codes 99214-25, 99212-59, 99213-59) which were denied for medical necessity. These services will not be a part of this review.

On 1-5-07 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. These services were denied by the Respondent as "47-These diagnoses are not covered, missing or are invalid," "246-The treatment has been determined to be unrelated to the extent of injury. Final adjudication has not taken place," "930-Preauthorization required, reimbursement denied," and "891-The insurance company is reducing or denying after reconsideration." These diagnoses: 844.1-(sprain and strain of MCL of knee) and 836 – (Other tear cartilage or meniscus knee current) are valid. A BRC was held on 11/8/06. The parties agree that the right knee medial meniscus tear, osteoarthritis, chondromalacia and degenerative joint disease are a part of the compensable injury. Per Rule 134.600 (h) these services were preauthorized in a letter from Texas Mutual dated 1-19-06. Recommend reimbursement per Rule 134.202(c)(1).

2. These services were denied by the Respondent as "47-These diagnoses are not covered, missing or are invalid," "246-The treatment has been determined to be unrelated to the extent of injury. Final adjudication has not taken place," and "891-The insurance company is reducing or denying after reconsideration." These diagnoses: 844.1-(sprain and strain of MCL of knee) and 836 – (Other tear cartilage or meniscus knee current) are valid. A BRC was held on 11/8/04. The parties agree that the right knee medial meniscus tear, osteoarthritis, chondromalacia and degenerative joint disease are a part of the compensable injury. Recommend reimbursement per Rule 134.202(b).

3. This service was denied by the Respondent as "47-These diagnoses are not covered, missing or are invalid," "246-The treatment has been determined to be unrelated to the extent of injury. Final adjudication has not taken place," and "891-The insurance company is reducing or denying after reconsideration." A BRC was held on 11/8/04. The parties agree that the right knee medial meniscus tear, osteoarthritis, chondromalacia and degenerative joint disease are a part of the compensable injury. Per Rule 134.202 this is a bundled service and will not be reimbursed separately.

4. This service was denied by the Respondent as "248-DWC 73 not properly complete or submitted in excess of the filing requirements, and "891-The insurance company is denying payment after reconsideration." The Requestor did properly submit this required report per Rule 129.5.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. §129.5
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §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 $2,200.05. 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:

		2-28-07
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.