



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: Nestor Martinez, D.C. 6660 Airline Drive Houston, TX 77076	MDR Tracking No.: M5-07-0569-01 Current M4-07-0733-01 (Prior)
	Claim No.:
	Injured Employee:
Respondent's Name: Indemnity Insurance Co. of North America Box# 15	Date of Injury:
	Employer's Name:
	Insurance Carrier#:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Requestor did not submit a Position Summary to MDR.

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not respond to the DWC 60, nor submit a Position Summary to MDR.

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)
01/05/06 – 02/17/06	172, & 42	97110	1, 2, 3, 4	\$529.75
TOTAL DUE				\$529.75

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. CPT Code 97110 for dates of service 01/05/06 – 02/17/06 was partially paid by Respondent with Reason Code, "172" (Payment is adjusted when performed/billed by a provider of this specialty) and "42" (Charges exceed our fee schedule or maximum allowable amount).
2. Requestor obtained pre-authorizations for CPT code 97110, (12 sessions) for dates 12/14/05 – 01/31/06 under Intercorp pre-authorization #PH272610A. Additional preauthorization was extended to 03/10/06 under preauthorization #PH282164A for 12 additional sessions.
3. The Respondent made a partial reimbursement for the pre-authorized services. The Respondent is in violation of Rule 134.600 (b) (1) (B) which states: "The carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (h) of this section when preauthorization was approved prior to providing health care.

4. Therefore reimbursement is recommended in the amount of **\$529.75**.
(\$28.69 X 125% = \$35.86 (MAR per Unit) X 44 (Units) = \$1,577.84 - \$1,039.94 (Carrier Payment) = \$537.90. The requestor is seeking \$529.75; this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1, 134.600
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION DECISION

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 **\$529.75**. 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.

Decision & Order by:

05/04/07

Authorized Signature

Typed Name

Date of Decision

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.