



**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity**

**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 Dr. Houston, TX 77076	MDR Tracking No.: M5-09-0004-01
	Previous Tracking No.: M5-06-1800-01
	Claim No.:
Respondent's Name and Address:  HARRIS COUNTY BOX 21	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Position summary states, "Please be advised that Pain and Recovery Clinic of North Houston files this Request for Medical Resolution. Please address all future correspondence regarding this matter to the address above."

Principle Documentation:

1. DWC-60 package
2. Amount sought: \$8,543.85
3. CMS-1500's
4. EOB's

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Position summary and (PLN11) states, "We are disputing entitlement of medical, income and/or other benefits involving the diagnosis/symptoms of severe levels of depression, moderate levels of anxiety, high levels of stress from pain, major depression disorder, moderate pain disorder associated with both psychological and medical conditions, significant vocational readjustment..."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

**PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services**

Dates of Service	CPT Codes and Calculations	Medically Necessary?	Amount Ordered
8-8-05 – 9-30-05	99212 (\$49.41 x 16 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$790.56
8-8-05 – 9-30-05	97140 (\$33.94 x 36 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,221.84
9-7-05 – 9-30-05	97110 (\$35.86 x 26 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$932.36
8-8-05 – 9-30-05	97112 (\$37.78 x 16 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$604.48
9-12-05, 9-14-05	97032 (\$20.34 x 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$40.68
10-5-05 – 11-28-05	99212, 97140, 97110, 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Total Due			\$3,589.92

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

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. Per Rule 134.202(b) and (c)(1) the amount due the Requestor for the items denied for medical necessity is \$3,589.92. The total amount sought by the Requestor was \$8, 543.85. The Requestor is not due a refund of the IRO fee,

The Requestor billed with the following Diagnosis codes: 724.4 – Thoracic/Lumbosacral Neuritis/Radiculitis and 723.4 – Brachial Neuritis or Radiculitis NOS. The Contested Case Hearing Decision and Order signed on May 1, 2008 states, "Claimants injury includes Cervical and Lumbar Radiculopathy, Cervical Spondylosis from C3-4 through C7-T1, Cord Compression at C4-5 and Stenosis from C3-4 through C7-T1."

Per review of Box 32 on CMS-1500, zip code 77076 is located in Harris County. Per review of Box 32 on CMS-1500, zip code is located in County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202  
Texas Labor Code Sec. § 413.011(a-d), 413.031, 413.0311  
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$3,589.92 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

**ORDER:**

Donna Auby,  
Medical Fee Dispute Resolution Officer

12-10-08

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**