



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.: M5-09-0005-01

Previous Tracking No.: M4-06-6981-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

GRAY INSURANCE CO INC
BOX 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "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. Total Amount Sought - \$4,446.02
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control...The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further the carrier challenges whether the charges are consistent with applicable fee guidelines..."

Principle Documentation:

1. DWC 60 package

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-6-05 – 7-27-05, 9-13-05, 9-16-05, 9-19-05	97110 (\$35.86 x 28 units)	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$1,004.08
7-6-05 – 7-27-05	97140 (\$33.94 x 11 units)	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$373.34
8-3-05 – 9-12-05, 9-14-05, 9-21-05 – 11-30-05	97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
8-3-05 – 8-22-05	97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Total Due			\$1,377.42

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. Texas Labor Code 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 has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the majority of the disputed medical necessity issues. Per Rule 134.202(c) the amount due the Requestor for the items denied for medical necessity is \$1,377.42.

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

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Sections 133.308, 134.1, 134.202
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 **additional** reimbursement for the services involved in this dispute. The Division has determined that the Requestor is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$1,377.42 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

Order:

Donna Auby, Medical Fee Dispute Officer

12-17-08

Authorized Signature

Typed Name

Date of Findings and Decision

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.