Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WACO ORTH REHAB
PO BOX 2850
BRYAN TX 77805

Respondent Name
COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-04-4653-01

MFDR Date Received
December 23, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment for certain medical services provided to the above captioned patient. It is our position that these services were reasonable, necessary, and related to the compensable injury. Appeals and follow up with the carrier have failed to resolve this dispute."

Amount in Dispute: $2,214.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier previously responded to this dispute on 1/21/04. The liability dispute originally reflected in the EOBs has been resolved. Payment will be made in accordance with the Medical Fee Guidelines. Accordingly, this dispute should be dismissed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2003 through April 21, 2003	95851, 97750-MT, 99213, 97150, 97110, 97250 and 97265	$2,214.00	$1,608.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.201 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 1 – The charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - 3 – By clinical practice standards, this procedure is incidental to the related primary procedure billed.
   - 4 – This charge has been reimbursed according to the appropriate fee schedule or usual and customary value.

- 1 – Date of this service exceeds 11 month time period for submission per Rule 134.801(C).
- 1 – Exceeds statute of limitations
- * – This item was previously submitted and reviewed with notification of decision issued to payor/provider.

Issues

1. Did the requestor submit an updated table of disputed services for review?
2. Did the requestor submit documentation to support the billing of the remaining disputed charges?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation supports that the requestor submitted an updated table of disputed services. The initial disputed amount was $12,469.33. The updated disputed amount is $2,124.00. The division, will therefore review the updated table in this dispute.
2. Former 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has provided copies of medical records to support the services in dispute.

   Review of the submitted documentation in the form of a SOAP note for dates of service February 18, 2003, February 21, 2003, February 24, 2003, February 28, 2003, March 28, 2003 and April 21, 2003 document the level of service billed. As a result, the requestor is entitled to reimbursement in the amount of $48.00/visit x 6 visits for a total recommended amount of $288.00. Therefore, this amount is recommended to the requestor.

   Review of the submitted documentation finds the following for dates of service:

   February 17, 2003, CPT code 97750-MT. Per the Medicine Ground Rules (I)(E)(3) "Muscle testing (97750-MT) requires a report identifying the service provided, results, and interpretation of the test and shall be reimbursed per body area (see section (I)(D)(1) of the ground rules for this section). If two or more contiguous areas are injured and if testing requires no additional tasks, then reimbursement shall be allowed for only one body area. Muscle testing shall not be reimbursed in addition to a functional capacity evaluation (FCE). Muscle testing shall not be reimbursed in addition to a functional capacity evaluation (FCE). Muscle testing may be used to replace any six components of the functional abilities test and shall be reimbursed (by time required) as a component of the FCE, not exceeding the MAR for an FCE." Review of the submitted documentation does not support the billing of CPT code 97750-MT, therefore, reimbursement is not recommended.

   February 18, 2003, CPT codes 97150, 97110, 97250 and 97265. The requestor submitted medical records to support the documentation of 15 minutes of CPT code 97150 and 120 minutes of CPT code 97110, one region of CPT code 97250 and one area of CPT code 97265. The requestor is therefore entitled to reimbursement for CPT code 97150 in the amount of $27.00; CPT code 97110 x 8 units (120 minutes) at $35.00/unit equal $280.00; CPT code 97250 in the amount of $43.00 and CPT code 97265 in the amount of $43.00. For a total recommended amount of $393.00.

   February 21, 2003, CPT codes 97110, 97150, 97250 and 97265. The requestor submitted medical records to support the documentation of 15 minutes of CPT code 97150 and 120 minutes of CPT code 97110, one region of CPT code 97250 and one area of CPT code 97265. The requestor is therefore entitled to reimbursement for CPT code 97150 in the amount of $27.00; CPT code 97110 x 8 units (120 minutes) at $35.00/unit equal $280.00; CPT code 97250 in the amount of $43.00 and CPT code 97265 in the amount of $43.00. For a total recommended amount of $393.00.

   February 24, 2003, CPT codes 97150, 97110, 97250 and 97265. The requestor submitted medical records to support the documentation of 15 minutes of CPT code 97150 and 120 minutes of CPT code 97110, one region of CPT code 97250 and one area of CPT code 97265. The requestor is therefore entitled to reimbursement for CPT code 97150 in the amount of $27.00; CPT code 97110 x 8 units (120 minutes) at $35.00/unit equal $280.00; CPT code 97250 in the amount of $43.00 and CPT code 97265 in the amount of $43.00. For a total recommended amount of $393.00.

   February 28, 2003, CPT codes 97150, 97110, 97250 and 97265. The requestor submitted medical records to support the documentation of 15 minutes of CPT code 97150 and 120 minutes of CPT code 97110, one region of CPT code 97250 and one area of CPT code 97265. The requestor is therefore entitled to reimbursement for CPT code 97150 in the amount of $27.00; CPT code 97110 x 8 units (120 minutes) at $35.00/unit equal $280.00; CPT code 97250 in the amount of $43.00 and CPT code 97265 in the amount of $43.00. For a total recommended amount of $393.00.

March 28, 2003, CPT codes 95851. The CPT code 95851 is defined as “Range of motion measurements and reports (separate procedure); each extremity (excluding hand) or each trunk section (spine).” The requestor submitted documentation to support the billing of CPT code 95851, as a result, the requestor is entitled to the MAR reimbursement of $36.00.

3. Review of the submitted documentation finds the requestor is entitled to an additional reimbursement in the amount of $1,608.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,608.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,608.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 20, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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