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
SUMMIT REHABILITATION CENTERS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-06-5217-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 11, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services can not be considered global or Incidental to any other on that date. . . . All fee guidelines have been followed for these services. . . . Therapy was preauthorized timely. . . . Services and office visits were well documented and notes are included here."

Amount in Dispute: $2,752.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent's position statement is extensive, detailed, and specific. The respondent's position cannot be summarized. Where appropriate, the respondent's position statement will be excerpted below.

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2005	Professional Medical Services	$2,752.17	$590.12

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 §129.5 sets out guidelines regarding work status reports.
2. 28 Texas Administrative Code §133.1 defines words and terms related to medical benefits.
3. 28 Texas Administrative Code §133.301 sets out the procedures for insurance carrier review of medical bills.
4. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
5. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
6. 28 Texas Administrative Code §133.308 sets out rules for independent review of medical necessity disputes.
7. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
8. 28 Texas Administrative Code §134.600 sets out rules for prospective and concurrent review of health care.

9. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 57 – PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY.
   - 860 – THE USUAL TREATMENT SESSION IN THE HOME OR OFFICE IS 30 - 45 MINUTES. MEDICAL NECESSITY FOR UNUSUAL LENGTH OF TIME WAS NOT DOCUMENTED.
   - 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
   - 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 864 – E/M SERVICES MAY BE REPORTED ONLY IF THE PATIENT'S CONDITION REQUIRES A SIGNIFICANT SEPARATELY IDENTIFIABLE E/M SERVICE.
   - 62 – PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION.
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.
   - 247 – EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED.
   - 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
   - 244 – UNNECESSARY MEDICAL.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 248 – DWC-73 NOT PROPERLY COMPLETED OR SUBMITTED IN EXCESS OF THE FILING REQUIREMENT; REIMBURSEMENT DENIED PER RULE 129.5.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.

Issues

1. What is the recommended payment amount for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c)(1), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Reimbursement is calculated as follows:

   - Per Medicare payment policy, reimbursement for procedure code A4556 (electrodes), date of service December 14, 2005, is included in the payment for G0283 (electrical stimulation) performed on the same date. The cost of supplies used in furnishing covered therapy is bundled and is not separately payable. Review of the requestor's S.O.A.P. note finds that the electrodes were used in furnishing covered therapy and are not separately reimbursable. Additional payment is not recommended.

   - Per Medicare payment policy, procedure code 95833, service date November 15, 2005, may not be reported with codes 99213 and 98940 performed on the same date. Reimbursement for this service is included in the payment for the other services. Additional payment is not recommended.

   - Per Medicare payment policy, procedure code 96004, service date November 15, 2005, is defined as "physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography)." Review of the submitted medical documentation finds that this service is not supported as billed. Reimbursement is not recommended.

   - The insurance carrier denied disputed procedure code 97116, service date November 15, 2005, with reason code 860 – "THE USUAL TREATMENT SESSION IN THE HOME OR OFFICE IS 30 - 45 MINUTES. MEDICAL NECESSITY FOR UNUSUAL LENGTH OF TIME WAS NOT DOCUMENTED." Per 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules

or fee guidelines)." Per 28 Texas Administrative Code §133.307(g)(2), effective January 1, 2003, 27 *Texas Register* 12282, "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution, therefore these disputed services will not be considered in this review.

- Per Medicare payment policy, procedure code 99213, service date November 17, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 99213, service date November 18, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 99213, service date November 28, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 99213, service date November 29, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- The insurance carrier denied disputed procedure code 99213, service date December 1, 2005, with reason code 247 – "EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED" Per 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines)." Per 28 Texas Administrative Code §133.307(g)(2), effective January 1, 2003, 27 *Texas Register* 12282, "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution, therefore these disputed services will not be considered in this review.
- The insurance carrier denied the following services with reason codes 62 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION" and 930 – "PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED."
    - Procedure code 97110, service date December 1, 2005;
    - Procedure code 97116, service date December 1, 2005;
    - Procedure code 97140-59, service date December 1, 2005;
    - Procedure code G0283, service date December 1, 2005;
    - Procedure code 97110, service date December 2, 2005;
    - Procedure code 97116, service date December 2, 2005;
    - Procedure code 97140-59, service date December 2, 2005;

- Procedure code 98940, service date December 2, 2005;
- Procedure code G0283, service date December 2, 2005;
- Procedure code 97110, service date December 5, 2005;
- Procedure code 97116, service date December 5, 2005; and
- Procedure code 97140, service date December 5, 2005.

Per Emergency Rule 28 Texas Administrative Code §134.600(b), 30 *Texas Register* 7624, effective December 1, 2005, "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care." Per §134.600(h)(1), the non-emergency health care requiring preauthorization includes "physical and occupational therapy services rendered on or after December 1, 2005." Documentation was presented to support that, although preauthorization was requested, it was not approved to start until after the above dates of service. No documentation was found to support an emergency. The insurance carrier's denial reasons are supported. Reimbursement for the above services cannot be recommended.

- The insurance carrier denied disputed procedure code 99213, service date December 1, 2005, with reason code 247 – "EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED" Per 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines)." Per 28 Texas Administrative Code §133.307(g)(2), effective January 1, 2003, 27 *Texas Register* 12282, "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution, therefore these disputed services will not be considered in this review.
- The insurance carrier denied disputed procedure code G0283, service date December 5, 2005, with reason codes 50 – "THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER" and 244 – "UNNECESSARY MEDICAL." Per 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines)." Per 28 Texas Administrative Code §133.307(g)(2), effective January 1, 2003, 27 *Texas Register* 12282, "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution, therefore these disputed services will not be considered in this review.
- The insurance carrier denied the following services with reason codes 62 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION" and 930 – "PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED." Review of the submitted information finds documentation to support that the services were preauthorized. Further, the respondent's position statement asserts that "DOS 12/07/05, 12/09/05, and 12/16/05: Texas Mutual will allow payment for the above DOS in accordance with the Medical Fee Guideline. Preauthorization approval was given for physiotherapy for DOS 12/06/2005 – 1/27/2006, the above listed dates of service fall within this time period." The Division therefore concludes that the denial reasons are not supported. Reimbursement is recommended according to applicable division rules as follows:

- Procedure code 97110, service date December 7, 2005, has a Medicare payment rate of $28.91, multiplied by 3 units is $86.73. This amount multiplied by 125% results in a MAR of $108.41. This amount is recommended.
- Procedure code 97116, service date December 7, 2005, has a Medicare payment rate of $25.38. This amount multiplied by 125% results in a MAR of $31.73. This amount is recommended.
- Procedure code 97140-59, service date December 7, 2005, has a Medicare payment rate of $27.33. This amount multiplied by 125% results in a MAR of $34.16. The provider used modifier code 59 to distinguish separate services from chiropractic manipulation code 98940 billed for the same date of service. Review of the S.O.A.P. notes finds that separate anatomical locations are documented. The modifier is supported. Payment is therefore recommended.
- Procedure code 97110, service date December 9, 2005, has a Medicare payment rate of $28.91, multiplied by 3 units is $86.73. This amount multiplied by 125% results in a MAR of $108.41. This amount is recommended.
- Procedure code 97116, service date December 9, 2005, has a Medicare payment rate of $25.38. This amount multiplied by 125% results in a MAR of $31.73. This amount is recommended.
- Procedure code 97140-59, service date December 9, 2005, has a Medicare payment rate of $27.33. This amount multiplied by 125% results in a MAR of $34.16. This amount is recommended.
- Procedure code 97110, service date December 16, 2005, has a Medicare payment rate of $28.91, multiplied by 3 units is $86.73. This amount multiplied by 125% results in a MAR of $108.41. This amount is recommended.
- Procedure code 97116, service date December 16, 2005, has a Medicare payment rate of $25.38. This amount multiplied by 125% results in a MAR of $31.73. This amount is recommended.
- Procedure code 97140-59, service date December 16, 2005, has a Medicare payment rate of $27.33. This amount multiplied by 125% results in a MAR of $34.16. The provider used modifier code 59 to distinguish separate services from chiropractic manipulation code 98940 billed for the same date of service. Review of the S.O.A.P. notes finds that separate anatomical locations are documented. The modifier is supported. Payment is therefore recommended.

- Per Medicare payment policy, procedure code 95851, service date December 9, 2005, may not be reported with codes 99213, 98940, and 97140 billed on the same date. Reimbursement for this service is included in the payment for the other services. Additional reimbursement is not recommended.
- Per Medicare payment policy, procedure code 96004, service date December 9, 2005, is defined as "physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography)." Review of the submitted medical documentation finds that this service is not supported as billed. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 99213, service date December 9, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- The insurance carrier denied procedure code 99080-73, service date December 14, 2005, with reason code 248 – "DWC-73 NOT PROPERLY COMPLETED OR SUBMITTED IN EXCESS OF THE FILING REQUIREMENT; REIMBURSEMENT DENIED PER RULE 129.5." Per Division rule at 28 Texas Administrative Code §129.5(d), "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee." No documentation was found to support that the work status report was filed in accordance with the requirements of §129.5. The insurance carrier's denial is supported. Reimbursement is not recommended.

- The insurance carrier denied disputed procedure code 99213, service date December 16, 2005, with reason code 247 – "EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED." Per 28 Texas Administrative Code §133.301(a), effective July 15, 2000, 25 *Texas Register* 2115, "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." Documentation supports that preauthorization was obtained; therefore the insurance carrier's denial reason is not supported. As medical necessity is not at issue, this service may be reviewed for fee dispute resolution. However, per Medicare payment policy, this code may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 99213, service date December 20, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 95833, service date December 21, 2005, may not be reported with codes 99213 and 98940 billed on the same date. Reimbursement for this service is included in the payment for the other services. Additional payment is not recommended.
- Per Medicare payment policy, procedure code 95851, service date December 21, 2005, may not be reported with codes 95833, 99213, 98940, and 97140 billed on the same date. Reimbursement for this service is included in the payment for the other services. Additional payment is not recommended.
- Per Medicare payment policy, procedure code 96004, service date December 21, 2005, is defined as "physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography)." Review of the submitted medical documentation finds that this service is not supported as billed. Reimbursement is not recommended.
- The insurance carrier denied disputed procedure code 98940, service date December 21, 2005, with reason code 247 – "EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED." Per 28 Texas Administrative Code §133.301(a), effective July 15, 2000, 25 *Texas Register* 2115, "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." Documentation supports that preauthorization was obtained; therefore the insurance carrier's denial reason is not supported. As medical necessity is not at issue, this service may be reviewed for fee dispute resolution. Review of the submitted S.O.A.P. notes finds that the service is supported as billed. This service has a Medicare payment rate of $26.89. This amount multiplied by 125% results in a MAR of $33.61. This amount is recommended.
- The insurance carrier denied disputed procedure code 98940, service date December 22, 2005, with reason code 247 – "EVIDENCE DOES NOT SUPPORT THE NEED FOR THE DURATION, INTENSITY AND/OR SERVICES BILLED." Per 28 Texas Administrative Code §133.301(a), effective July 15, 2000, 25 *Texas Register* 2115, "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." Documentation supports that preauthorization was obtained; therefore the insurance carrier's denial reason is not supported. As medical necessity is not at issue, this service may be reviewed for fee dispute resolution. Review of the submitted S.O.A.P. notes finds that the service is supported as billed. This service has a Medicare payment rate of $26.89. This amount multiplied by 125% results in a MAR of $33.61. This amount is recommended.
- Per Medicare payment policy, procedure code 99213, service date December 22, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 95831, service date December 27, 2005, may not be reported with codes 95833, 99213 and 98940 billed on the same date. Reimbursement for this service is included in the payment for the other services. Additional payment is not recommended.

- Per Medicare payment policy, procedure code 95833, service date December 27, 2005, may not be reported with codes 99213 and 98940 billed on the same date. Reimbursement for this service is included in the payment for the other services. Additional payment is not recommended.
- Per Medicare payment policy, procedure code 96004, service date December 27, 2005, is defined as "physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report. Motion analysis is performed in a dedicated motion analysis laboratory (ie, a facility capable of performing videotaping from the front, back and both sides, computerized 3-D kinematics, 3-D kinetics, and dynamic electromyography)." Review of the submitted medical documentation finds that this service is not supported as billed. Reimbursement is not recommended.
- Per Medicare payment policy, procedure code 99213, service date December 29, 2005, may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted S.O.A.P. notes finds that the service is not supported. Reimbursement is not recommended.

2. The total recommended payment for the services in dispute is $590.12. Review of the submitted documentation finds that the insurance carrier has paid $0.00 towards the disputed services, leaving an amount due to the requestor of $590.12. This amount is recommended.

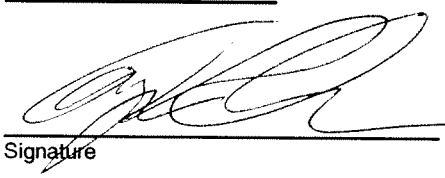
Conclusion

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 $590.12.

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 $590.12 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature



Signature | Grayson Richardson, Medical Fee Dispute Resolution Officer | May 2, 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.