MDR Tracking M5-02-2534-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on

I. DISPUTE

1. Whether there should be reimbursement for CPT codes 97032, 97035, 97010, 97250, 97122, 99213-MP, 97110, 95900, 95904, 95935, 95861, 99244, 93740, 95831, A4215, A4556, and A4558.

II. RATIONALE

1. The requestor billed for 97032 – electrical stimulation with a MAR of $22.00/15 min on 12-21-01, 12-24-01, 12-26-01, 12-28-01, 12-31-01, 1-3-02, 1-16-02, 1-17-02, and 1-21-02. The insurance carrier denied reimbursement for dates of service 12-21-01, 12-24-01, 12-26-01, 12-28-01, 12-31-01 and 1-3-02 based upon the service not being documented, EOB denial code "N". A review of the medical records documented service rendered; therefore, reimbursement in accordance with *Medical Fee Guideline*, (MFG), 6 X $22.00 = $132.00.

   The insurance carrier denied reimbursement for dates of service 1-16-02, 1-17-02, and 1-22-02 based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, these dates of service will be reviewed in accordance with MFG. The requestor documented electrical stimulation for 1-16 and 1-17-02, and 1-21-02; therefore, reimbursement of 3 X $22.00 = $66.00 is recommended.

2. The requestor billed for 97035 – Ultrasound with a MAR of $22.00/15 min on 12-21-01, 12-24-01, 12-26-01, 12-28-01, 12-31-01, 1-3-02, 1-16-02, 1-17-02, and 1-21-02. The insurance carrier denied reimbursement for dates of service 12-21-01, 12-24-01, 12-26-01, 12-28-01, 12-31-01 and 1-3-02 based upon the service not being documented, EOB denial code "N". A review of the medical records documented service rendered; therefore, reimbursement in accordance with *Medical Fee Guideline*, (MFG), 6 X $22.00 = $132.00.

   The insurance carrier denied reimbursement for dates of service 1-16-02, 1-17-02, and 1-22-02 based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, these dates of service will be reviewed in accordance with MFG. The requestor documented Ultrasound for 1-16 and 1-17-02, and 1-21-02; therefore, reimbursement of 3 X $22.00 = $66.00 is recommended.

3. The requestor billed for 97010 – hot or cold packs with a MAR of $11.00 on 12-21-01, 12-24-01, 12-26-01, 12-28-01, 12-31-01, 1-3-02, and 1-17-02. The insurance carrier denied reimbursement for dates of service 12-21-01, 12-24-01, 12-26-01, 12-28-01, 12-31-01 and 1-3-02 based upon the service not being documented, EOB denial code "N". A review of the medical records documented service rendered; therefore, reimbursement in accordance with *Medical Fee Guideline*, (MFG), 6 X $11.00 = $66.00.

   The insurance carrier denied reimbursement for date of service 1-17-02 based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, this date of service will be reviewed in accordance with MFG. The requestor documented Hot packs on 1-17-02; therefore, reimbursement of $11.00 is recommended.

4. The requestor billed for 97250 – Myofascial Release with a MAR of $43.00 on 12-21-01, 12-24-01, 1-16-02, and 1-21-02. The insurance carrier denied reimbursement for dates of service 12-21-01 and 12-24-01based upon the service not being documented, EOB denial code "N". A review of the medical records documented service rendered; therefore, reimbursement in accordance with *Medical Fee Guideline*, (MFG), 2 X $43.00 = $86.00.

   The insurance carrier denied reimbursement for dates of service 1-16-02, and 1-21-02 based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, these dates of service will be reviewed in accordance with MFG. The requestor documented myofascial release on 1-16 and 1-21-02; therefore, reimbursement of 2 X $43.00 = $86.00 is recommended.

5. The requestor billed for 97122 – Manual Traction with a MAR of $35.00 / 15 min on 12-26-01, 12-28-01, and 1-3-02. The insurance carrier denied reimbursement for dates of service 12-26-01 and 12-28-01based upon the service not being documented, EOB denial code "N". A review of the medical records documented service rendered; therefore, reimbursement in accordance with *Medical Fee Guideline*, (MFG), 2 X $35.00 = $70.00.

   The insurance carrier denied reimbursement for dates of service 1-3-02 based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, this date of service will be reviewed in accordance with MFG. The requestor documented manual traction on 1-3-02; therefore, reimbursement of $35.00 is recommended.

6. The requestor billed for 99213MP – Office Visit with Manipulation with a MAR of $48.00 on 1-16-02, 1-17-02 and 1-21-02. The insurance carrier denied reimbursement based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, these dates of service will be reviewed in accordance with MFG.
7.

The requestor documented office visits with manipulation on above dates; reimbursement of 3 X $48.00 = $144.00 is recommended.

7. The requestor billed for 97110 – Therapeutic Procedures (1 on 1) with a MAR of $35.00 / 15 min. on 1-16-02, 1-17-02 and 1-21-02. The insurance carrier denied reimbursement based upon "T". Per HB2600, Rule 134.1001 was abolished on 1-1-2002; therefore, the insurance carrier was incorrect to deny reimbursement based upon an abolished treatment guideline. Therefore, these dates of service will be reviewed in accordance with MFG. The requestor did not document one to one supervision as required in Medicine Ground Rule (I)(A)(9)(b); therefore no reimbursement is recommended.

8. The requestor billed $130.00 for CPT code 95900 - motor NCV with a MAR of $64.00 each nerve on 1-22-02. The insurance carrier paid $80.64 with EOB code "S". The report supports testing of tibial nerves; therefore, the appropriate reimbursement per MFG = $128.00. The difference between amount paid of $80.64 and amount due of $128.00 is = $47.36.

9. The requestor billed $130.00 for CPT code 95904 - sensory NCV with a MAR of $64.00 each nerve on 1-22-02. The insurance carrier paid $80.64 with EOB code "S". The report supports testing of sural nerves; therefore, the appropriate reimbursement per MFG = $128.00. The difference between amount paid of $80.64 and amount due of $128.00 is = $47.36.

10. The requestor billed $240.00 for CPT code 95935 – H and F wave study with a MAR of $53.00 per extremity on 1-22-02. The insurance carrier paid $33.39 with EOB code "S". The report supports testing of H and F wave studies on lower extremities; therefore, the appropriate reimbursement per MFG = 4 X $53.00 = $212.00. The difference between amount paid of $33.39 and amount due of $212.00 is = $178.61.

11. The requestor billed $200.00 for CPT code 95861 – needle EMG two extremities with a MAR of $200.00 on 1-22-02. The insurance carrier paid $126.00 with EOB code "S". The report supports testing on lower extremities; therefore, the appropriate reimbursement per MFG = $200.00. The difference between amount paid of $126.00 and amount due of $200.00 is = $74.00.

12. The requestor billed $148.00 for CPT code 99244 – office consult with a MAR of $148.00 on 1-22-02. The insurance carrier paid $133.20 with EOB code "S". A consult report was not submitted to support billed service in accordance with MFG, Evaluation and Management Ground Rule (IX)(A) and (B). Therefore, no reimbursement is recommended.

13. The requestor billed $85.00 for CPT code 93740 – Temperature Gradient study with a MAR of $84.00 on 1-22-02. The insurance carrier paid $00.00 with EOB code "D". A report was not submitted to support billed service. Therefore, no reimbursement is recommended.

14. The requestor billed $33.00 for CPT code 95831 – Manual muscle testing separate procedure with report with a MAR of $29.00 on 1-22-02. The insurance carrier paid $26.00 with EOB code "S". A report was not submitted to support billed service. Therefore, no reimbursement is recommended.

15. The requestor billed for A-4215 – needles at $30.00; A4556 – electrodes at $100.00; and A4558 – conductive paste at $60.00 on 1-22-02. The insurance carrier denied reimbursement based upon "D." The General Instructions Ground Rule (IV) states that a provider may bill for supplies and materials provided over and above those usually included in the office visit. The provider failed to document that billing of these supplies was above those included in procedure or office visit; therefore, no reimbursement is recommended.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Medical Review Division has determined that the requestor **is** entitled to reimbursement for CPT code(s) 97032, 97035, 97010, 97250, 97122, 99213-MP, 95900, 95904, 95935, 95861, in the amount of **$1241.33.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$1241.33** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Decision and Order are hereby issued this 5th day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division