TEXAS WORKERS' COMPENSATION COMMISSION
MEDICAL REVIEW DIVISION, MS-48
MEDICAL DISPUTE RESOLUTION
DECISION

Highpoint Pain Clinic **800 W. Arbrook Blvd., Suite 300** **Arlington, TX 76015**	§ § §	
Requestor	§	**MDR TRACKING #: M5-02-2893-01**
	§	**TWCC FILE #:**
V.	§	**CLAIMANT:**
	§	**DOI:**
Texas Mutual Insurance Company **Commission Rep. Box 54**	§ §	
Respondent		

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

The Medical Review Division (Division) reviewed the information submitted by the parties in the captioned medical fee dispute and has issued the enclosed Findings and Decision.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Tex. Admin. Code § 102.5 (d). A request for hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, TX 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party, involved in the dispute.

I hereby verify that a copy of this Decision was placed in the insurance carrier representative's box and mailed to the requestor applicable to Commission Rule 102.5 this _____ day of _____, 2004. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date the Decision was placed in the Austin Representative's box.

Signature of Commission Employee: _____

Printed Name of Commission Employee:_____

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 Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 3/7/02.

I. DISPUTE

Whether there should be additional reimbursement for 76499-27-22, 76499-27, 99499-RR, A4550, A4649, A4209, A4215, A4646, J1040 and J2912 from 6/11/01 through 8/6/01.

II. RATIONALE

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
6/11/01	76499-27-22	$350.00	88.00	M	DOP	Rule 133.307 (g)(3)(D)	DOP Radiographic procedure. Rule 133.307 (g)(3)(D) requires the requestor to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. The requestor failed to submit documentation supporting that the amount billed should be considered fair and reasonable. Additional reimbursement is not recommended.
	76499-27	$300.00	0.00	F	DOP	See above.	See above. Reimbursement is not recommended.
	99499-RR	$50.00	50.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4550	$75.00	74.47	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4649	$15.00	15.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4209	$10.61	0.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4215	$90.00	14.40	M	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4646	$100.00	55.00	M	N/A	N/A	Per Table of Disputed Services not in dispute.
	J1040	$100.00	16.52	M	N/A	N/A	Per Table of Disputed Services not in dispute.
	J2912	$25.00	2.29	M	N/A	N/A	Per Table of Disputed Services not in dispute.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
7/9/01	76499-27-22	$350.00	262.00	M	DOP	Rule 133.307 (g)(3)(D)	DOP Radiographic procedure. Rule 133.307 (g)(3)(D) requires the requestor to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. The requestor failed to submit documentation supporting that the amount billed should be considered fair and reasonable. Additional reimbursement is not recommended.
	99499-RR	$50.00	0.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4550	$75.00	50.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4649	$15.00	15.00	G	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4209	$10.00	.67	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4215	$90.00	14.40	M	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4646	$100.00	100.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	J1040	$100.00	16.52	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	J2912	$25.00	2.29	G	N/A	N/A	Per Table of Disputed Services not in dispute.
8/6//01	76499-27-22	$350.00	42.00	M	DOP	Rule 133.307 (g)(3)(D)	DOP Radiographic procedure. Rule 133.307 (g)(3)(D) requires the requestor to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. The requestor failed to submit documentation supporting that the amount billed should be considered fair and reasonable. Additional reimbursement is not recommended.
	76499-27	$300.00	0.00	F	DOP	See above.	See above. Reimbursement is not recommended.
	99499-RR	$50.00	0.00	F	DOP	MFG, MGR, (V)((B)(3)	Postoperative monitoring is reimbursed hourly per MFG. . Rule 133.307 (g)(3)(D) requires the requestor to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. The requestor failed to submit documentation supporting that the amount billed should be considered fair and reasonable. Additional reimbursement is not recommended

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
	A4550	$75.00	74.47	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4649	$15.00	15.00	F	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4209	$10.00	10.00	G	DOP	MFG, SGR, (C)(B)(1)	Syringe with needle. Surgery Ground Rule V. (B)(1) states "Sterile trays (which include all supplies, gloves, utensils, needles, suture material, etc., needed to perform the procedure). These shall be billed using CPT code 99070-ST. Reimbursement is the lesser of the doctor's usual charge or fair and reasonable reimbursement. The requestor billed the syringe with needle - A4209. The requestor did not use code 99070 with the appropriate modifier ST and unbundled the sterile tray items on the HCFA. Reimbursement for these services is not recommended.
	A4215	$90.00	0.00	M	N/A	N/A	Per Table of Disputed Services not in dispute.
	A4646	$100.00	0.00	M	DOP	MFG, SGR, (V)(B)(1)	Surgery Ground Rule V. (B)(1) states "Sterile trays (which include all supplies, gloves, utensils, needles, suture material, etc., needed to perform the procedure). These shall be billed using CPT code 99070-ST. Reimbursement is the lesser of the doctor's usual charge or fair and reasonable reimbursement. DOP is required if charges are $50.00 or greater." The requestor billed the materials using the individual HCPCS code, contrast material - A4646. The requestor did not use code 99070 with the appropriate modifier ST and unbundled the sterile tray items on the HCFA. Reimbursement for this service is not recommended.
	J1040	$100.00	16.52	M	N/A	N/A	Per Table of Disputed Services not in dispute.
	J2912	$25.00	2.29	M	N/A	N/A	Per Table of Disputed Services not in dispute.
TOTALS							$00.00

III. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for 76499-27-22, 76499-27, 99499-RR, A4550, A4649, A4209, A4215, A4646, J1040 and J2912.

The above Findings and Decision are hereby issued this ___30___day of April, 2004.

Medical Dispute Resolution Officer
Medical Review Division