

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

**Marcos Rodriguez, D.C.  
6300 Samuell Blvd., Suite 112  
Dallas, TX 75228**

**Requestor**

**V.**

**Arch Insurance Company  
Commission Rep. Box 19**

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**MDR TRACKING #: M5-03-1885-01  
TWCC FILE #:  
CLAIMANT:  
DOI:**

**Respondent**

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**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, Decision and Order.

**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 1/22/02.

### **I. DISPUTE**

Whether there should be reimbursement for 97545-WH, 97546-WH, 99213, 97750-FC, 95851, 97265, 97250, 97122, 97750-MT from 1/30/01 through 10/26/01.

### **II. FINDINGS**

Per Rule 133.307(d)(1) services more than 365 days old are outside Commission jurisdiction. On this basis, all services prior to 1/22/01 will not be addressed in this decision.

Commission Rules 133.307(j)(2) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an request. Any new denial reasons or defenses raised shall not be considered in the review."

The disputed services were initially disputed on the basis of entitlement. At a Contested Case Hearing held on 12/19/02 the injured worker prevailed on the issues of compensability. The information submitted by both the requestor and respondent indicate the disputed services were again reviewed for medical necessity on 1/31/03. This second audit is after the filing of the dispute and therefore, can not be considered in this decision under Rule 133.307(j)(2). On this basis, the services in dispute will be reviewed based upon the Medical Fee Guideline.

Per Commission Rule 133.307 (e)(2)(B), "(2) Each copy of the request shall be legible, include only a single copy of each document, and shall include:

(B) a copy of each explanation of benefits (EOB) or response to the refund request relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB;

## III. RATIONALE

| DOS                         | CPT CODE   | Billed     | Paid   | EOB Denial Code | MARS (Maximum Allowable Reimbursement) | Reference                 | Rationale  |
|-----------------------------|--|------------|--------|-----------------|--|---------------------------|--|
| 4/19/01<br>thru<br>5/15/01  | 97545WH<br>x 12 days<br>at<br>\$102.40 a<br>day. | \$1,228.80 | \$0.00 | No<br>EOB       | \$64.00 per hour.                      | Rule 133.307<br>(e)(2)(B) | No properly filed EOB was submitted by either the requestor or respondent. The requestor failed to provide convincing evidence in the form of a signed certified mail card that the missing EOBs had been pursued. Reimbursement is not recommended. |
| 4/19/01<br>thru<br>5/10/02  | 97546WH<br>x 7 days<br>at<br>\$307.20 a<br>day.  | \$2,150.40 | \$0.00 | No<br>EOB       | \$64.00 per hour.                      | See above.                | See above.   |
| 4/20/01<br>thru<br>5/15/01  | 97546WH<br>x 5 days<br>at<br>\$258.00 a<br>day.  | \$1,290.00 | \$0.00 | No<br>EOB       | \$64.00 per hour.                      | See above.                | See above.   |
| 4/23/01<br>thru<br>10/26/01 | 99213 x<br>15 units at<br>\$48.00<br>per unit    | \$ 720.00  | \$0.00 | No<br>EOB       | \$48.00                                | See above.                | See above.   |
| 4/25/01                     | 97750FC  | \$ 200.00  | \$0.00 | No<br>EOB       | \$100.00 per hour.                     | See above.                | See above.   |
| 7/27/01<br>thru<br>9/17/01  | 95851 x 2<br>units at<br>\$36.00<br>per unit     | \$ 72.00   | \$0.00 | No<br>EOB       | \$36.00                                | See above.                | See above.   |
| 8/3/01<br>THRU<br>10/26/01  | 97750MT<br>x 3 units<br>at \$43.00<br>per unit.  | \$ 129.00  | \$0.00 | No<br>EOB       | \$43.00                                | See above.                | See above.   |
| 9/17/01                     | 97265  | \$ 43.00   | \$0.00 | No<br>EOB       | \$43.00                                | See above.                | See above.   |
|                             | 97250  | \$ 43.00   | \$0.00 | No<br>EOB       | \$43.00                                | See above.                | See above.   |
|                             | 97122  | \$ 35.00   | \$0.00 | No<br>EOB       | \$35.00                                | See above.                | See above.   |

| DOS      | CPT CODE | Billed     | Paid   | EOB Denial Code | MARS (Maximum Allowable Reimbursement) | Reference           | Rationale  |
|----------|----------|------------|--------|-----------------|--|---------------------|--|
| 9/26/01  | 99213    | \$ 48.00   | \$0.00 | E               | \$48.00                                | Rule 133.307 (j)(2) | Denied by the carrier on the basis of entitlement. A Contested Case Hearing was held 12/19/02 and the injured worker prevailed. A second audit was conducted 1/13/03; however, this audit was done after the filing of the dispute and will therefore not be considered in this decision. The carrier did not use the proper denial code. Reimbursement of \$48.00 is recommended. |
|          | 97750MT  | \$ 43.00   | \$0.00 | E               | \$43.00                                | See above.          | See above. Reimbursement of \$43.00 is recommended.  |
| 10/1/01  | 99213    | \$ 48.00   | \$0.00 | E               | \$48.00                                | Rule 133.307 (j)(2) | Denied by the carrier on the basis of entitlement. A Contested Case Hearing was held 12/19/02 and the injured worker prevailed. A second audit was conducted 1/13/03; however, this audit was done after the filing of the dispute and will therefore not be considered in this decision. The carrier did not use the proper denial code. Reimbursement of \$48.00 is recommended. |
| 10/12/01 | 99213    | \$ 48.00   | \$0.00 | E               | \$48.00                                | See above.          | See above. Reimbursement of \$48.00 is recommended.  |
| TOTAL    |          | \$6,098.20 | \$0.00 |                 |  |                     | The requestor is entitled to reimbursement of \$187.00   |

#### IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for 99213 97750MT in the amount of **\$187.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit **\$187.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 18<sup>th</sup> day of August, 2004.

Medical Dispute Resolution Officer  
Medical Review Division