

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 10/23/03.

I. DISPUTE

Whether there should be additional reimbursement for 99213, 97010, 97014, 97124, 20550, J2000, 99214-25, 67500 and 99070-ST from 10/30/02 through 3/3/03.

II. FINDINGS

The Table of Disputed Services submitted by the requestor also included dates of service from 10/30/02 through 3/3/03, all denied for medical necessity. The requestor failed to pay the IRO fee as required per Rule 133.308. All services denied or reduced for medical necessity were subsequently dismissed by the Commission and will not be included in this Decision.

III. RATIONALE

Per Commission Rule 133.307 (e)(2)(A-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;

The 1996 MFG General Instructions Ground Rule III (A) states that “Documentation of procedure (DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill. DOP is used when the services provided are not specifically listed or are unusual or too variable to have an assigned MAR. The required documentation may vary based on the complexity of the procedure...”

Section 408.21 of the Texas Labor Code states, “(a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

- (1) cures or relieves the effects naturally resulting from the compensable injury;
- (2) promotes recovery; or
- (3) enhances the ability of the employee to return to or retain employment.”

MDR Tracking Number: M5-04-0566-01

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
11/7/02	97124	\$36.00	\$0.00	No EOB	\$ 28.00	Rule 133.307 (e)(2)(B)	No EOBs were submitted by either the requestor or respondent. The requestor is required to furnish "convincing evidence of carrier receipt of the provider request for an EOB" and failed to do so. Reimbursement is not recommended.
	97010	\$14.00	\$0.00	No EOB	\$ 11.00	See above.	See above.
	97014	\$19.00	\$0.00	No EOB	\$ 15.00	See above.	See above.
11/25/02	97124	\$36.00	\$28.00	F	\$ 28.00	N/A	Per EOB paid by carrier. No additional reimbursement is recommended.
	97010	\$14.00	\$11.00	F	\$ 11.00	N/A	See above.
	97014	\$19.00	\$15.00	F	\$ 15.00	N/A	See above.
2/19/03	J2000	\$64.00	\$0.57	M	DOP	MFG, General Instructions (III)(A)	The requestor failed to submit documentation supporting the amount billed as fair and reasonable as required by MFG, GI,(III)(A). Reimbursement is not recommended.
2/28/03	99214-25	\$92.00	\$0.00	G	\$ 71.00	MFG, Surgery Ground Rules, (II)(B)(2)(c)	Per the carrier the requestor billed for an office visit at the same time as a starred procedure 20550. Per MFG, billing for follow up office visit not allowed. Reimbursement is not recommended.
	67500	\$380.00	\$152.00	D	\$152.00	Texas Labor Code Section 408.021 (a)(1-3)	Only the duplicate EOB was submitted by the requestor. On this basis, this service will be reviewed per the Medical Fee Guideline. The medical report of 2/28/03 verifies delivery of service. Reimbursement of \$152.00 is recommended.
	99070-ST	\$250.00	\$0.00	F	DOP	MFG, General Instructions (III)(A)	The requestor failed to submit documentation supporting the amount billed as fair and reasonable as required by MFG, GI,(III)(A). Reimbursement is not recommended.
TOTALS							Reimbursement of \$152.00 is recommended.

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 67500 in the amount of **\$152.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit **\$152.00** 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 25th day of May 2004.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

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