

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x)HCP ( )IE ( )IC		<b>Response Timely Filed?</b> (x)Yes ( )No	
Requestor's Name and Address  Integra Specialty Group, PA 517 North Carrier Parkway Suite G Grand Prairie TX 75050		MDR Tracking No.: M5-05-1987-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address BOX #: 19  Northern Insurance Co. of New York c/o FOL		Date of Injury:	
		Employer's Name:	
		Insurance Carrier's No.:	

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11-29-04	12-16-04	95851, 96004, 97012, 97140, 99213, 97110, 97032, 95833	\$2,398.54	\$502.03

## PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement dated 3-14-05 states in part, "On February 7, 2005, our request for reconsideration was received by Zurich American Ins. 1110 Perimeter Drive Schaumburg IL, 60173-5844, regarding the bills for the claimant \_\_\_\_\_. The carrier has failed to provide the original response EOB's for the dates of 11/29/04, 12/02/04, 12/06/04, 12/9/04, 12/10/04, 12/14/04, 12/15/04, and 12/16/04. Also, the Carrier has failed to provide any reconsideration response EOB's..."

## PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response dated 4-5-05 states in part, "... The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

On 3-31-05, the Requestor submitted a withdrawal for dates of service denied as unnecessary medical - 3-29-04, 4-8-04, 11-9-04, 11-23-04, 11-30-04, 12-1-04, 12-7-04, 12-8-04, and 12-13-04.

Code 99213 billed on 6-1-04 was paid on 7-7-04 with check # 00001874853239; therefore, no medical dispute exists.

The following dates of service had no EOBs submitted by either party. Requestor submitted convincing evidence of carrier receipt of request for EOBs. Therefore, these dates of service will be reviewed per the 2002 MFG.

Codes 95851, 96004, 97012, 97140, and 99213 billed for date of service 11-29-04.

- Code 95851 is global to 99213; therefore no reimbursement recommended.
- Code 96004 – recommend reimbursement of \$118.42 x 125% = \$148.03.
- Code 97140 is mutually exclusive to code 97012. A modifier is allowed in order to differentiate between the services provided. An appropriate modifier was not billed; therefore, no reimbursement recommended.
- Code 99213 – recommend reimbursement of \$52.14 x 125% = \$65.18.

Codes 97012, 97140, 97110, 99213 billed for date of service 12-2-04.

- Code 97012 – recommend reimbursement of  $\$14.83 \times 125\% = \$18.54$
- Code 97140 is mutually exclusive to code 97012. A modifier is allowed in order to differentiate between the services provided. The requestor did not bill with an appropriate modifier; therefore, no reimbursement recommended.
- Code 99213 – recommend reimbursement of  $\$52.14 \times 125\% = \$65.18$ .
- Code 97110 - One-to-one therapy was not documented. The notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment. No reimbursement recommended

Codes 97012, 97032, 97110, 97140, 99213 billed for dates of service 12-6-04, 12-9-04, and 12-10-04.

- Code 97012 – recommend reimbursement of  $\$14.83 \times 125\% = \$18.54$
- Code 97140 is mutually exclusive to code 97012. A modifier is allowed in order to differentiate between the services provided. The requestor did not bill with an appropriate modifier; therefore, no reimbursement recommended.
- Code 99213 – recommend reimbursement of  $\$52.14 \times 125\% = \$65.18$ .

Codes 95833, 96004, 97012, 97032, 97110, 97140, 99213 billed for 12-14-04.

- Code 95833 is a component of code 99213. A modifier is not allowed. Therefore, no reimbursement recommended.
- Code 96004 – no daily note submitted. No reimbursement recommended.
- Code 97012 – no daily note submitted. No reimbursement recommended.
- Code 97140 is mutually exclusive to 97012. A modifier is allowed in order to justify separate reimbursement. A modifier was not included on the table. No reimbursement recommended.
- Code 99213 – no daily note submitted. No reimbursement recommended.
- Code 97032 – no daily note submitted. No reimbursement recommended.

Codes 97032, 97110, 97140, 99213 billed for 12-15-04 and 12-16-04.

- Code 97032 – recommend reimbursement of  $\$15.06 \times 125\% = \$18.83 \times 2 \text{ units} = \$37.66$
- Code 97110 – One-to-one therapy was not documented. The notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment. No reimbursement recommended.
- Code 97012 – recommend reimbursement of  $\$14.83 \times 125\% = \$18.54$
- Code 97140 is mutually exclusive to 97012. A modifier is allowed in order to justify separate reimbursement. Requestor did not bill an appropriate modifier, therefore, no reimbursement recommended.
- Code 99213 – recommend reimbursement of  $\$52.14 \times 125\% = \$65.18$ .

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$502.03. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Ordered by:

Dee Z. Torres

8-16-05

Authorized Signature

Typed Name

Date

**PART VIII: 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 a hearing must be in writing and the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you 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 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 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 their written request for a hearing to the opposing party involved in the dispute.

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

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_