

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-7485.M5

MDR Tracking #: M5-05-2015-01

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 Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 10-09-03.

I. DISPUTE

Whether there should be additional reimbursement for CPT code 64999 for date of service 01-31-03.

II. FINDINGS

The medical necessity issue for date of service 02-13-03 was withdrawn on 04-27-05. Per Rule 133.307(g)(3), a Notice was submitted to the requestor on 04-28-05 requesting the requestor to submit additional documentation necessary to support the fee charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

III. RATIONALE

CPT code 64999 date of service 01-31-03 denied with denial code "M/RD" (No MAR/ reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with labor code 413.011(B)). The carrier has made a payment of \$29.35. This is a DOP code. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate." Relevant information (i.e. redacted EOBs- with same or similar services- showing amount billed is fair and reasonable) was submitted by the requestor to confirm that \$255.00 is their usual and customary charge for this service. Per Rule 133.307(g)(3)(D), the Requestor has provided sample EOBs as evidence that the fee billed is for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Additional reimbursement is recommended in the amount of **\$225.65 (\$255.00 minus carrier payment of \$29.35).**

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to additional reimbursement for CPT code 64999.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay the unpaid medical fees for date of service 01-31-03 totaling additional reimbursement of \$225.65 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003.

The above Findings and Decision and Order are hereby issued this 18th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division