Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Summit Rehabilitation Centers 2500 West Freeway # 200 Fort Worth, Texas 76102	MDR Tracking No.: M5-05-2750-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TML Intergovernmental Risk Pool Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 dispute package. Position summary: Per the table of disputed services "necessary treatment"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60. Position summary: This is a fee dispute involving issues of causal relation. In particular, the carrier contends that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-09-04 to 12-31-04	99354, 96004, 99213, 97018, 97110, 95832, 95852, 97750-FC, 97140, 97112 and 97116	☒ Yes ☐ No	$6,558.81
01-07-05 to 03-14-05	99213 (one visit per month or dates of service 01-07-05, 02-18-05 and 03-14-05)	☒ Yes ☐ No	$196.32
01-07-05 to 03-14-05	99213 (more than one visit per month or dates of service 01-14-05, 01-19-05, 01-28-05, 01-31-05 and 02-22-05)	☐ Yes ☒ No	$0.00
02-18-05	99354	☐ Yes ☒ No	$0.00

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

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the **majority** of disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-05-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99213 date of service 07-09-04 denied with denial codes 130/F (services unsubstantiated by documentation and Fee Guideline MAR reduction). The carrier has made no payment. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the service billed. Reimbursement is recommended in the amount of **$65.17.**

CPT code 97018 dates of service 09-09-04 and 09-10-04 denied with denial codes F/R79 (Fee Guideline MAR reduction/ Standards of medical/surgical practice). The carrier has made no payment. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation supporting the services billed. Reimbursement is recommended in the amount of **$16.60 ($8.30 X 2 DOS).**

CPT code 99213 date of service 09-09-04 denied with denial code F (Fee Guideline MAR reduction). A payment by the carrier in the amount of $44.11 was made. Additional reimbursement in the amount of **$21.07** is recommended.

HCPCS code A9300 date of service 09-09-04 denied with denial codes R4/F (non-covered procedure/Fee Guideline MAR reduction). The carrier has made no payment. HCPCS code A9300 is not listed on the 2004 DMEPOS fee schedule. No reimbursement recommended.

CPT code 95852 date of service 10-06-04 denied with denial codes G/R79 (unbundling/ Standards of medical/surgical practice). Per the 2002 Medical Fee Guideline code 95852 is a component procedure of code 99213 billed on the same date of service. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately.

CPT code 96004 date of service 10-06-04 denied with denial code G (unbundling). Per the 2002 Medical Fee Guideline code 96004 is not global to other services billed on 10-06-04. Reimbursement is recommended in the amount of **$148.03.**

CPT code 99213 date of service 10-06-04 denied with denial code (unbundling). Per the 2002 Medical Fee Guideline code 99213 is not global to other services billed on 10-06-04. Reimbursement is recommended in the amount of **$65.17.**

Review of CPT code 97750-FC date of service 10-12-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **$427.92.**

CPT code 99080-73 dates of service 11-26-04 and 01-21-05 denied with denial code V (unnecessary treatment with peer review). Per Rule 129.5 this service is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **$30.00 ($15.00 X 2 DOS).** A Compliance and Practices referral will be made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 129.5, 133.307(e)(2)(B), 133.307(g)(3)(A-F), 134.202 and 2004 DMEPOS Fee Schedule

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of $7,529.09 . In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of $460.00. 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 30 days of receipt of this Order.

Findings and Decision by:

		12-15-05
Authorized Signature		Date of Findings and Decision

Order by:

	12-15-05
Authorized Signature	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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