

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Beeville Medical Associates P.O. Box 33306 San Antonio, Texas 78265-3306	MDR Tracking No.: M5-05-2845-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
		No medical necessity items.		

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

In a letter dated 7-20-05 the Requestor withdrew the items denied for medical necessity. Therefore, the file contains unresolved medical fee issues only. The Division shall proceed to resolve the medical fee dispute in accordance with Rule 133.307.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it they are filed with the division no later than one (1) year after the date(s) of service in dispute. The following dates of service are not timely and is not eligible for this review: 6-15-04 - 6-18-04.

The requestor withdrew CPT code 97112 on 7-7-04. This service will not be a part of this review.

On 7-21-05 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 97110 on 7-6-04, 7-7-04 and 7-30-04 was denied as "01 – the charge for the procedure exceeds the amount indicated in the fee schedule." The carrier indicates that they have made a partial payment for these services. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

The requestor billed two units of CPT code 97112 on both 7-6-04 and 7-30-04. One unit on each date was denied as "U". The other unit was denied as "01 – the charge for the procedure exceeds the amount indicated in the fee schedule." The requestor states that the insurance carrier has not made a partial payment on this service. Recommend reimbursement per Commission Rule 134.202(c)(1) of \$68.60 (\$34.30 X 2 DOS).

Regarding CPT code G0283 on 7-6-04, 7-7-04 and 7-30-04 – The carrier denied as "01 – the charge for the procedure exceeds the amount indicated in the fee schedule." The requestor states that the insurance carrier has not made a partial payment on this service. Recommend reimbursement per Commission Rule 134.202(c)(1) of \$40.23 (\$13.41 X 3 DOS).

PART IV: COMMISSION DECISION AND ORDER

The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines, totaling \$108.83 plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-12-05

Authorized Signature

Typed Name

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

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

Signature of Insurance Carrier: _____ Date: _____

PART VI: 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 it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk 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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.