



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: Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231	MDR Tracking No.: M5-05-2910-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Encasco Insurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's. The requestor submitted a position statement which stated, "Per TWCC Rule 134600(b)(1)(B) the carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care. The requestor cited Texas labor Code 408.021 which states "an employee who sustains a compensable injury is entitled to all health care reasonable required by the nature of the injury as and when needed." The requestor also submitted a preauthorization authorizing individual psychotherapy one time a week for four weeks and biofeedback therapy one time a week for four weeks.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The carrier states that "the requestor is attempting to bill for more time than was authorized without providing any explanation why. The provider has billed for reports and hypnotherapy which are not authorized or necessary. The carrier has paid in conformity with the applicable fee guidelines. No further reimbursement is due." The carrier sent the TWCC 60.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
	Medical Necessity Issues were withdrawn by the requestor.		

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

In a letter dated 8-18-05 the requestor withdrew CPT code 90901 for 11-9-04, 3-11-05, and 3-17-05. 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.

Based on review of the disputed issues within the request, the 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 8-10-05 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.

The carrier denied CPT code 90806 on 11-9-04 as "435-the value of this procedure is included in the value of the comprehensive procedure." Per the 2002 MFG this procedure is a component of CPT code 90901. Recommend no reimbursement.

The carrier denied CPT code 90880 on 11-9-04 as "F-Fee schedule Mar Reduction." Per the 2002 MFG this procedure is a component of CPT code 90901. Recommend no reimbursement.

The carrier denied CPT code 90889 on 11-9-04, 3-11-05, 3-17-05 and 4-8-05 as "F-Fee schedule Mar Reduction." Per the 2002 MFG this preparation of report is a bundled code. Recommend no reimbursement.

The EOB shows that CPT code 90880 on 3-11-05 and 3-17-05 was paid by the insurance carrier. Recommend no additional reimbursement.

Regarding CPT code 90901 on 4-8-05: The descriptor for code 90901 does not include a time element. Therefore, time is not considered a factor when using this code to identify the service performed. Recommend payment of \$47.39 for one unit.

The carrier denied CPT code 90880 on 4-8-05 as "240-authorization not obtained." Per the 2002 MFG this procedure is a component of CPT code 90901. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202(b).

PART VII: DIVISION DECISION

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 \$47.39. 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 and Order by:

Donna Auby

9-16-05

Authorized Signature

Typed Name

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.