



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-3078-01
Real Health Care 12605 E. Fwy. Suite 507 Houston, TX 77015	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TX Mutual Insurance Company, Box 54	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's.

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	Medical Necessity Services were withdrawn.		

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

In a letter dated 9-1-05 the Requestor withdrew all services 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.

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 9-12-05 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 99212 on 8-16-04, 8-17-04, 8-18-04, 8-19-04, 8-20-04 was denied by the carrier as "CAC-57-Payment denied because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply." Per Rule 133.307 (g)(B) the additional documentation that the requestor must submit shall include "pertinent medical records or other documents relevant to the fee dispute." Recommend no reimbursement.

CPT code 97032 on 8-30-04 and 8-31-04 was denied as “01 - the charge exceeds the amount listed in the fee schedule.” Recommend reimbursement per the 2002 MFG of \$37.46 (\$18.73 X 2 DOS).

CPT code 99212 on 9-02-04, 9-7-04, 9-22-04, 9-24-04, 9-27-04 and 9-29-04 was denied by the carrier as “227-The report was not included with the billing. This charge will be reevaluated upon receipt of the report.” Per Rule 133.307 (g)(B) the additional documentation that the requestor must submit shall include “pertinent medical records or other documents relevant to the fee dispute.” Recommend no reimbursement.

CPT code 97140 and 97140-59 on 9-02-04, 9-8-04, 9-20-04, 9-23-04, 9-24-04 and 9-29-04 were denied by the carrier as “227-The report was not included with the billing. This charge will be reevaluated upon receipt of the report.” Per Rule 133.307 (g)(B) the additional documentation that the requestor must submit shall include “pertinent medical records or other documents relevant to the fee dispute.” Recommend no reimbursement.

CPT code 97032 on 9-07-04 was denied by the carrier as “227-The report was not included with the billing. This charge will be reevaluated upon receipt of the report.” Per Rule 133.307 (g)(B) the additional documentation that the requestor must submit shall include “pertinent medical records or other documents relevant to the fee dispute.” Recommend no reimbursement.

CPT code 99214 on 9-08-04 was denied by the carrier as “227-The report was not included with the billing. This charge will be reevaluated upon receipt of the report.” Per Rule 133.307 (g)(B) the additional documentation that the requestor must submit shall include “pertinent medical records or other documents relevant to the fee dispute.” Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307

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 \$37.46. 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:

Authorized Signature

Typed Name

10-06-05

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.