



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:	MDR Tracking No.: M5-05-3138-01
Killeen Rehab Group 5445 La Sierra Dr. #204 Dallas, TX 75231	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 45	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 position summary states, "The patient's recovery would have been negatively impacted without these treatments. The services rendered were medically necessary, the MAR was not paid."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The position summary states, "Some dates of service had not been resubmitted for reconsideration in accordance with Rule 133.304(k). The requestor has not submitted justification for more than 45 minutes of therapy in one setting as established in the Medicare guidelines for physical rehabilitation or evidence that the patient's severity of injury warrants this length of treatment."

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	Medical Necessity Items were withdrawn by the requestor.		

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

In a letter dated 9-19-05 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.

On 8-17-05 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.

On 10-10-05 the Division transmitted a fax and an e-mail to the requestor asking for confirmation of payment and proof of resubmission of the CMS 1500 forms. The fax was confirmed, however no response was made to the Division.

Regarding CPT code 72040 on 9-17-04: Neither the carrier nor the requestor submitted original EOB's. The resubmission EOB states that "Services have been previously paid. No additional allowance recommended." Attempts to contact the requestor to confirm payment failed. No additional reimbursement recommended.

Regarding CPT code 97124 on 10-13-04: Neither the carrier nor the requestor submitted original EOB's. The respondent's position paper states that additional reimbursement was made. Attempts to contact the requestor to confirm payment failed. No additional reimbursement recommended.

Regarding CPT code 99213 on 10-13-04 and 99212 on 2-28-05: Per the 2002 MFG this service is included in the payment for the chiropractic manipulation CPT code 98943. No additional reimbursement recommended.

Regarding CPT code 98943 on 10-13-04 and CPT codes 95904, 95936 and 95900 on 11-23-04: The EOB's submitted by the respondent indicate that these services were reimbursed. Attempts to contact the requestor to confirm payment failed. No additional reimbursement recommended.

Regarding CPT code 97110 on 10-13-04, 1-5-05, 1-7-05, 1-21-05, 1-28-05 and 2-8-05: The EOB's indicate that 3 units of this service on each date were reimbursed. Attempts to contact the requestor to confirm payment failed. 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. No additional reimbursement recommended.

Regarding CPT codes 99213, 97124, 97110, 97112 and 97530 on 10-15-04 and 10-25-04: The EOB's submitted by the requestor indicate that these services were reimbursed according to the 2002 MFG. Attempts to contact the requestor to confirm payment failed. No additional reimbursement recommended.

CPT code 97124 on 11-22-04 and 2-8-05 was denied by the carrier as "G-Unbundling." CPT code 97124 is considered by Medicare to be a component procedure of the CPT code 98940. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. No reimbursement recommended.

CPT code 97112 on 11-22-04 was denied by the carrier as "G-Unbundling." CPT code 97112 is considered by Medicare to be a component procedure of the CPT code 98940. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. No reimbursement recommended.

CPT codes 97124, 97110, 97112 and 97530 on 1-3-05 were denied by the carrier as "N – not appropriately documented." The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement recommended.

CPT code 90806, 90880, 90889 on 1-19-05 were denied by the carrier as "G-Unbundling." These codes are considered by Medicare to be a component procedure of the CPT code 90901. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. No reimbursement recommended.

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 no additional reimbursement.

Findings and Decision and Order by:

10-12-05

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.