



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: Pain & Recovery Clinic-North 6660 Airline Drive Houston, TX 77076	MDR Tracking No.: M5-05-3168-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Employers Mutual Casualty 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 position summary states, "The Nurse Review Unit has reviewed medical records."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included a TWCC 60. The position summary states, "These charges were denied on grounds of a failure to document medical necessity and unnecessary medical treatment. Continued chiropractic care has not been documented to be of any value in this case."

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)
	The medical necessity issues were withdrawn by the requestor.		\$0

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

In a letter dated 9-26-05 the Requestor withdrew 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.

Based on review of the disputed issues within the request, the 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 9-2-05 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 1-3-05, 1-5-05, 1-10-05, 1-11-05, 1-14-05, 1-17-05, 1-19-05, 1-21-05, 1-24-05, 1-26-05, 1-28-05 and 1-31-05 was denied by the carrier as "N – not appropriately documented", "241-not documented" or "205-this charge was disallowed as additional information/definition is required to clarify service/supply rendered". The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F) including documentation of face to face contact and a daily note telling why it was necessary and what the injury was. Reimbursement of \$1,651.86 is recommended (\$35.91 X 46 units).

CPT code 97140 on 1-3-05, 1-5-05, 1-10-05, 1-11-05, 1-14-05, 1-17-05, 1-19-05, 1-21-05, 1-24-05, 1-26-05, 1-28-05 and 1-31-05 was denied by the carrier as “N – not appropriately documented”, “241-not documented” or “205-this charge was disallowed as additional information/definition is required to clarify service/supply rendered”. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$407.28 is recommended. (\$33.94 X 24 units).

CPT code 97112 on 1-3-05, 1-5-05, 1-10-05, 1-11-05, 1-14-05, 1-17-05, 1-19-05, 1-21-05, 1-24-05, 1-26-05, 1-28-05 and 1-31-05 was denied by the carrier as “N – not appropriately documented”, “241-not documented” or “205-this charge was disallowed as additional information/definition is required to clarify service/supply rendered”. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement of \$451.18 is recommended. (\$36.69 X 2 DOS plus \$37.78 X 10 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307 and 134.202

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 \$2,510.32. 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

10-14-05

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.