

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address  Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, Texas 75231	MDR Tracking No.: M5-05-3186
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  American Insurance Company, Box 19	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			
8-17-04	10-04-05	CPT code 90806	\$375.00	0
8-17-04	10-04-05	CPT code 90889	\$720.00	0
8-17-04	10-04-05	CPT code 90880	\$52.14	0
8-17-04 and 9-28-04		CPT code 90901	\$1,980.00	\$106.12

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

In letters dated 7-20-05 and 7-26-05 the Requestor withdrew dates of service CPT code 90901 on 9-21-04 and 10-4-04 and CPT code 90806 on 9-21-04. These services will not be a part of this review. 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 8-11-05 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.

Per the 2002 MFG:

CPT code 90889 is always a bundled service and will not be reimbursed separately.

CPT code 90806 is bundled with 90901 and 90880 and will not be reimbursed separately.

CPT code 90880 is bundled with 90901 and will not be reimbursed separately.

Regarding CPT code 90901 on 8-17-04: In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 7-14-04 for four sessions of Biofeedback Therapy. The carrier denied these sessions as "C – negotiated contract" and "397-preauthorization." The Requestor states that there is no contract. Per the 2002 MFG 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 reimbursement per Rule 134.202 (c)(1) of \$53.06.

Regarding CPT code 90901 on 9-28-04: In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 7-14-04 for four sessions of Biofeedback Therapy. Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Per the 2002 MFG 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 reimbursement per Rule 134.202 (c)(1) of \$53.06.

**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 \$106.12 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

8-26-05

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 esta correspondencia, favor de llamar a 512-804-4812.**