



**MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity and Fee Dispute**

**PART I: GENERAL INFORMATION**

<b>Type of Requestor:</b> <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address:  Summit Rehabilitation Centers 2500 W. Freeway #200 P.O. Box 380395 Ft. Worth, TX 76102	MDR Tracking No.: M5-05-3328-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  American Zurich Insurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents include the TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "The carrier has failed to follow Rule 133.304 which states 'The insurance carrier shall send, the explanation of benefits to the appropriate parties. Per Rule 133.307 any new denial reasons or defenses raised shall not be considered in the review.'"

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents include the Explanations of Benefits. Position summary states, "The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. The carrier challenges whether the charges are consistent with applicable fee guidelines. The documentation provided does not establish medical necessity."

**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	Medical Necessity services were withdrawn by the requestor.		

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

In a letter dated 9-12-05 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.

On 9-13-05 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.

Regarding CPT code 99213 on 8-17-04: 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). Recommend reimbursement of \$68.24.

Regarding CPT code 99080-73 on 8-18-04: 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). Recommend reimbursement of \$15.00.

Regarding CPT code 99080-73 on 9-20-04 and 10-18-04: The carrier denied this with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

CPT code 99090 on 10-12-04 was denied by the carrier as "N – not appropriately documented." The requestor did not provide documentation or Clinical Notes to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement recommended.

1 unit of CPT code 95851 on 12-7-04 was denied as "F-Fee guideline MAR reduction." Per the 2002 MFG "Testing determines active and passive range of motion for extremities and joints. This code applies to manually testing each arm or leg or sections of the spinal muscles in a separately reported procedure." Recommend additional reimbursement of \$26.29.

CPT code 95851 on 1-25-05 was denied as "G – Unbundling." This code is considered by Medicare to be a component procedure of codes 99213 and 97140. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. No reimbursement recommended.

CPT code 95831 on 2-15-05 had no denial code: This CPT code is considered by Medicare to be a component procedure of the 99213. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. No reimbursement recommended.

Regarding CPT codes 96004, 97110, 97140, 99213 and G0283 on 2-15-05: The EOB states that these services were reimbursed. However, the requestor states that no reimbursement was received. Per the 2002 MFG CPT code 97140 is bundled with CPT code 95831. Recommend reimbursement as follows:

CPT code 96004	\$155.25
CPT code 97110	\$144.56
CPT code 99213	\$ 68.31
CPT code G0283	\$14.65

CPT code 99213 on 2-16-05, 2-21-05, 2-22-05, 2-23-05, 3-2-05, and 3-8-05 was denied as "M: NL – Bundling". Per the 2002 MFG CPT code 98940 "includes a patient assessment" (or an office visit). No reimbursement recommended.

Regarding CPT codes 97012, 97110, 97140, 99213 and G0283 on 2-17-05: The EOB states that these services were reimbursed. However, the requestor states that no reimbursement was received. Per the 2002 MFG CPT code CPT code 99213 is bundled with 98940. Recommend reimbursement as follows:

CPT code 97110	\$144.56
CPT code G0283	\$14.65
CPT code 97012	\$19.01
CPT code 97140-59	\$34.13
CPT code 98940	\$33.61

**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 \$768.26. 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:

		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.**