



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: Houston Pain Recovery c/o Bose Consulting LLC PO Box 550496 Houston TX 77255	MDR Tracking No.: M5-06-0171-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: Texas Mutual Insurance Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position summary: Treatment provided for the claimant was medically reasonable and necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position summary: This dispute involves the carrier's payment for date of service 6-7-04 to 1-18-05. The requestor billed \$14,153.87 and Texas Mutual paid \$0.00. The requestor believes it is entitled to an additional \$14,153.87.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-26-04 to 1-18-05	Medical necessity issues were dismissed on 12-6-05 due to nonpayment of the requested IRO fee	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Disputed dates of service 6-7-04 through 8-23-04 are untimely and ineligible for review per Rule 133.308.

Carrier submitted proof of payment for disputed dates of service 8-26-04 to 9-16-04. Therefore, these are not part of this review.

Requestor submitted letter of withdrawal for the following disputed dates of service that have been paid: 10-14-04 (97110, 97112), 11-4-04 (97032), 1-3-05, 1-4-05, and 1-18-05 (all procedures on these three dates). Therefore, these are not part of this review.

On 10-18-05, Medical Review 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.

99212 billed on 9-20-04 was denied as ‘864 – E/M services may be reported only if the patient’s condition requires a significant separately identifiable E/M service.’ Per the 2002 Medical Fee Guideline, a modifier is allowed to signify a separately identifiable E/M service. The requestor did not bill with a modifier. Therefore, no reimbursement recommended.

Codes 97110 and 97112 billed on 11-4-04 had no EOB submitted by either party. The requestor did not submit convincing evidence of carrier receipt of that request; therefore, no review can be conducted.

Code 99070 (theraband) billed on dates of service 11-24-04 and 12-21-04 was denied as ‘284 – no allowance was recommended as this procedure indicates a status B.’ Per the 2002 Medical Fee Guideline, the reimbursement for this code is bundled into the office visit and/or other service performed on the same day. Therefore, no separate reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 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 not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

_____, Medical Dispute Officer

12-9-05

Authorized Signature

Typed Name

Date

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.