



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

**PART I: GENERAL INFORMATION**

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Southeast Health Services P. O. Box 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-0718-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Dallas ISD, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents include the DWC 60 package. Position paper states, "The attached forms and notes clearly document the service billed."

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

Documents include the DWC 60 response. Position paper states, "The medical records do not justify the use of this code. No additional allowance is recommended."

**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)
	Requestor withdrew medical necessity services.		

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

In a letter dated 1-4-06 the Requestor stated that she did not wish to go to IRO, but wished to pursue the fee issues. 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.

Services on dates of service 1-11-05, 1-14-05, 1-17-05 and 1-26-05 were denied as "F-72-Treatment has exceeded Medicare Guidelines for length of treatment sessions." Services on date of service 2-16-05 were denied, as "152A-Documentation does not support the medical necessity for treatment exceeding 45 minutes." These items were denied for medical necessity and will not be a part of this review.

On 1-05-06 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 99354-25 on 1-5-05 was denied by the carrier as “G90-Unbundling.” Per the 2002 MFG this service is not global to any other service billed on this date. Recommend reimbursement of \$127.49.

CPT code 99214 on 1-18-05 was denied by the carrier as “G90-Unbundling.” Per the 2002 MFG this service is considered by Medicare to be a component procedure of CPT code 98940. 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. A modifier was used to differentiate the services. Recommend reimbursement of \$107.01.

CPT code 99214 on 2-28-05 was denied by the carrier, as “97H-Payment is included in the allowance for another service.” Per the 2002 MFG this service is considered by Medicare to be a component procedure of CPT code 98940. 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. A modifier was used to differentiate the services. Recommend reimbursement of \$107.01.

**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 \$341.51. 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:

Donna Auby

2-6-06

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.**