



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

|  |   |
|--|---|
| <b>Type of Requestor:</b> (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier                            |   |
| Requestor's Name and Address:<br><br><b>South Coast Spine and Rehab<br/>620 Paredes Line Rd<br/>Brownsville TX 78521</b> | MDR Tracking No.: M5-06-1323-01<br>Prev. MDR Tracking No.: Previously M4-05-0329-01 |
|  | Claim No.:  |
|  | Injured Worker's Name:  |
| Respondent's Name and Address:<br><br><b>c/o Dean Pappas &amp; Assoc Box 29</b>  | Date of Injury:   |
|  | Employer's Name:  |
|  | Insurance Carrier's No.:  |

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

PRINCIPLE DOCUMENTATION: DWC-60 package

POSITION SUMMARY: "It is our position that since the care given was medically necessary, compensable and we followed the TWCC Medical Fee Guidelines as established by the Commission, we are entitled to reimbursement in full according to the guidelines."

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

PRINCIPLE DOCUMENTATION: Response to DWC-60

POSITION SUMMARY: In a letter dated 4-29-05, the carrier states in part, "...no additional payment is due for the dates of service... The charges were reduced in accordance with the Commission medical policies and fee guidelines in effect on the date of service. The charges... were reduced on the basis of the Fee Guideline MAR as well as for time parameters or procedural limits being exceeded. Per Trailblazer LCD: Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries-Y-13B-R6: ...the usual treatment session provided in the home or office setting is 30-45 minutes. The medical necessity of services for an unusual length of time must be documented as described in the 'Documentation Requirements' section of this policy."

### PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service  | Denial Code | CPT Code(s) or Description  | Part V Reference | Amount Due (if any) |
|---------------------|-------------|---|------------------|---------------------|
| 11-8-04             | 0840, F, N  | 97750-FC \$477.40 in dispute. Per email from carrier on 5-2-06, this amount was paid on 2-10-06 on check #315216; therefore, no dispute exists. |                  | \$ 0.00             |
| 11-9-04 to 12-2-04  | F, 615      | 97035 \$14.81 x 8 units =   | 1,2              | \$118.48            |
| 11-17-04 to 12-2-04 |             | 97124 \$26.28 x 8 units =   | 1,2              | \$210.24            |
| 11-29-04 to 12-2-04 |             | 97113 \$38.91 x 3 additional units =  | 1,2              | \$116.73            |
| 11-17-04 to 12-2-04 |             | 97032 \$18.73 x 4 units =   | 1,2              | \$ 74.92            |
|                     |             | <b>Total Due</b>  |                  | <b>\$520.37</b>     |

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

- The carrier denied the services with reason code "0615 – time parameters or procedural limits are exceeded" and "F – fee guideline MAR reduction." carrier representative of Dean G Pappas and Associates emailed a statement on 4-27-06 stating "M5-06-1323 covers dos 11-8-04 through 12-2-04. These dates have been paid per the fee guides and no additional payments are due. Please redocket M5-06-1323 as a fee

*dispute.*” Therefore, the disputed dates of service will be reviewed per Rule 134.202. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement as listed.

2. A referral will be made to Compliance and Regulations due to the carrier not using payment exception denial reasons that correspond with the carrier’s Statement of Position and/or narrative description of denial reasons.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. § 413.011(a-d)  
28 Texas Administrative Code Sec. §134.1, 134.202, 133.307

**PART VII: DIVISION DECISION AND ORDER**

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 \$520.37.**

Ordered by:

5-12-06

Medical Dispute Resolution Officer

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.**