Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address: South Coast Spine and Rehabilitation, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M5-06-1325-01 Old MDR # M4-05-9325-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: .Dean Pappas & Associates Rep Box 29	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60

POSITION SUMMARY: "This dispute is a medical fee dispute and not a medical necessity dispute. Medical necessity is not an issue in a medical fee dispute according to Rule 133.307(a). Therefore, we are entitled to submit this request".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "It is the position of the Carrier that no additional payment is due for the dates of service made the basis of the dispute. The charges were reduced in accordance with the Commission medical policies and fee guidelines in effect on the date of service. The charges with explanation code "F" 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 to 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. No additional reimbursement is due the Requestor for the dates of service made the basis of this dispute".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
01-27-05	97124 < MAR billed 97032 < MAR billed	(1)	$26.28 $18.73
01-31-05 to 02-16-05	97032 (1 unit @ $18.73 X 5 DOS) < MAR billed 97124 (1 unit @ $26.28 X 4 DOS) < MAR billed 97035 (1 unit @ $14.63 X 6 DOS) **see note below	(2)	$93.65 $105.12 $73.15
02-17-05 to 03-02-05	97035 (1 unit @ $14.63 X 4 DOS) > MAR billed 97032 (1 unit @ $19.00 X 2 DOS) 97124 (2 units @ $53.26 X 3 DOS) 97113 ($35.47 X 2 DOS)(balance after carrier payment)	(3)	$58.52 $38.00 $159.78 $70.94
02-22-05	97750-FC (16 units @ $35.63 =$570.08 – $71.40 payment)	(4)	$498.68
03-02-05	97113 (4 units @ $152.20) 99213	(5)	$152.20 $61.89
	**note: no reimbursement for DOS 2-16-05 recommended due to no documentation submitted for review by Requestor		
	TOTAL		$1,356.94

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

(1) The carrier denied the service with denial code "F" (Fee guideline MAR reduction). The requestor submitted documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement is recommended as listed above per Rule 134.202.

(2) The carrier denied the service with denial code "W1" (Workers Compensation State Fee Schedule Adjustment). The requestor submitted documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement is recommended as listed above per Rule 134.202.

(3) The carrier denied the service with denial codes "W1" (Workers Compensation State Fee Schedule Adjustment) and "0615" (time parameters or procedural limits are exceeded). , carrier representative, of Dean G. Pappas and Associates, submitted an e-mail dated 04-13-06 which states, "Please redocket this as a fee dispute. No medical necessity issues were raised for the dates of service made the basis of this dispute". The requestor submitted documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement is recommended as listed above per Rule 134.202 (minus any carrier payment).

(4) The carrier denied the service with denial codes "0840" (Allowance exceeds a maximum of three times for each case), "00W1" (Workers Compensation State Fee Schedule Adjustment), "0941" (Documentation does not support the necessity for evaluation and/or continued use of treatment) and "0050" (these are non-covered services because this is not deemed a medical necessity by the payer). , carrier representative, of Dean G. Pappas and Associates, submitted an e-mail dated 04-13-06 which states, "Please redocket this as a fee dispute. No medical necessity issues were raised for the dates of service made the basis of this dispute". The carrier made a partial payment of $71.40. The Requestor submitted documentation for review, which indicated this, was the initial functional capacity evaluation. Per Rule 133.307(g)(3(A-F) the documentation submitted supports the service. Additional reimbursement per Rule 134.202 is recommended as listed above.

(5) The carrier denied the service with denial code "0144" (unnecessary treatment with peer review). , carrier representative, of Dean G. Pappas and Associates, submitted an e-mail dated 04-13-06 which states, "Please redocket this as a fee dispute. No medical necessity issues were raised for the dates of service made the basis of this dispute". The Requestor submitted documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Reimbursement is recommended as listed above per Rule 134.202.

A Compliance and Regulations referral will be made due to the carrier not having payment exception denial codes, which correspond with the carrier Statement of Position, and/or narrative description of denial code.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202 and 133.307(g)(3)(A-F)

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 $1,356.94. 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.

Ordered by:

		04-18-06
Authorized Signature		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.