



## 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:  Summit Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.:                      M5-06-1423-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Texas Construction Trust, 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, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

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

Documents include DWC 60 response.

#### 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 4-21-05 the Requestor withdrew all dates of service which were 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 5-3-06 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 97110 (3 units) on 9-15-05 was denied by the carrier as "W1-Workers Compensation state fee adjustment." The carrier made no payment and gave no valid reason for not doing so. The SOAP notes, which were submitted with the dispute, do delineate exclusive one-on-one treatment and explain the severity of the injury to warrant exclusive one-to-one therapy. Recommend reimbursement of \$108.42.

CPT code 97750- on 10-24-05 (16 units) was denied by the carrier as “W1-Workers Compensation state fee adjustment.” The carrier made no payment and gave no valid reason for not doing so. Rule 134.202(e)(4) states, “A maximum of three FCE’s for each compensable injury shall be billed and reimbursed. FCE’s shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test. Documentation is required.” Information was submitted which reveals that this is an initial FCE test. The requester is billing for a 4 hour FCE or \$618.40.

CPT code 99080-73 on 12-13-05 was denied by the carrier as “W9-unnecessary treatment.” The Requestor did submit the report which verified a change in status for the injured worker. The Medical Review Division has jurisdiction in this matter. Recommend reimbursement of \$15.00.

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

28 Texas Administrative Code Sec. 129.5, 133.307, 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 entitled to reimbursement in the amount of \$741.82. 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:

\_\_\_\_\_  
Authorized Signature

Donna Auby, Medical Dispute Officer  
\_\_\_\_\_  
Typed Name

5-10-06  
\_\_\_\_\_  
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.**