



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Active Behavioral Healthcare 2420 E Randoll Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-06-1478-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Amerisure Mutual Insurance Company, Box 47	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 included DWC 60 response. Position paper states, "We contend that treatment was not reasonable and necessary in line with peer report."

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)
	In a letter dated 4-20-06 the Requestor withdrew all dates of service except 7-8-05, 8-8-05 and 12-29-05		

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

In a letter dated 9-26-05 the Requestor withdrew all dates of service except 7-8-05, 8-8-05 and 12-29-05. 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.

Regarding CPT code 99080-73 on 7-8-05 and 8-8-05: The carrier denied CPT Code 99080-73 with a "U" for unnecessary medical treatment; however, the DWC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

CPT code 99455-VR was denied with denial code "U" (unnecessary treatment). CPT code 99455-VR is a DWC required report and not subject to an IRO review, therefore was denied inappropriately. A referral will be made to Compliance and Practices for this violation. The billing of CPT code 99455-VR is in compliance with Rule 134.202(e)(6)(F). Reimbursement of \$50.00 is recommended for CPT code 99455-VR.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5, 133.307, 134.202(e)(6)(F).

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 \$80.00. 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

4-24-06

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.