



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity and Fee Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address:  Dr. Jack A. Sloane, D. C. P.O. Box 972 Decatur, TX 76234	MDR Tracking No.: M5-06-1675-01
	Previous #: M4-03-4164-01
	Claim No.:
Injured Employee's Name:	
Respondent's Name and Address:  American Alternative Ins Corp, Box 17	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, "There have been denials on multiple dates of service that are not consistent with TWCC guidelines and/or the services provided, therefore, we ask for your assistance in resolving the medical dispute."

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

Documents included DWC 60 response. Position paper states, "Attached is the additional documentation you have requested."

#### 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 5-30-06 the Requestor withdrew all services 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.

Date of service 2-27-02 per Rule 133.308(e)(1) was not timely filed and is ineligible for review

On 5-23-06 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.

3 units of CPT code 97032 on 3-5-02 were denied by the carrier as "N-not documented." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$66.00.

CPT code 97139-AC on 3-5-02 and 3-20-02 was denied by the carrier as “N-not documented.” The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend no reimbursement.

CPT code 99213 on 3-5-02 and 3-20-02 were denied by the carrier as “N-not documented.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$96.00.

3 units of CPT code 97032 on 3-20-02 were denied by the carrier as “28-A reduction was made for reasons indicated in note below or on the attached note or letter.” There was no “note below” to explain the reduction. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$66.00.

CPT code 97032 on 7-31-02 and 8-7-02 was denied by the carrier as “01-The charge for the procedure exceeds the amount in the fee schedule.” The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement of \$44.00.

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

28 Texas Administrative Code Sec. 133.307, 133.308(e)(1), 134.202, 1996 MFG

**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 \$272.00. 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:

\_\_\_\_\_, Medical Dispute Officer

5-31-06

\_\_\_\_\_  
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.**