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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

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

Requestor=s Name and Address:	MDR Tracking No.: M5-07-0009-01
Carl M. Naehritz III, D.C. 2900 Highway 121 Suite 120 Bedford, TX 76021	Claim No.: Injured Employee's Name:
Respondent's Name and Address: Federal Insurance Company Box 17	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: As stated in Requestors' Table of Disputed Services, Requestor states that "Treatment enhanced the ability to return to or retain employment."

Principle Documentation:

1. DWC 60
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a Position Summary to MDR.

Principle Documentation:

1. The Respondent did not submit a response to MDR

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09/14/05 – 05/08/06	On 10/23/06, Requestor Withdrew the Medical Necessity Issues of this Dispute	☐ Yes ☐ No	N/A

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

Based on review of the disputed issues within the request, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that will be reviewed by Medical Dispute Resolution.

On 10/31/06, Medical Dispute Resolution 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.

HCPS Code A4595 for date of service 04/19/05 was untimely filed and not eligible for review per Rule 133.307(d)(1).

CPT code 99213-59 & L3807 for dates of service 03/08/06 and 05/12/06 were withdrawn by the Requestor on 10/27/06, therefore these services are no longer in dispute.

HCPCS Code A4595-RR billed for dates of service 10/15/05, 11/08/05,12/06/05, and 01/10/06 "W1" (WC State Fee Schedule Adjust. Rental fees are applicable for short-term utilization unless the doctor provides medical justification for an extension beyond the initial 60 days (TX MFG page 253), 97" (Payment is included in the allowance for another service. Included in global reimbursement. Reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). The services were billed by themselves, therefore were not global. HCPCS Code A4595 was also billed with modifier SU, which is addressed in the next paragraph.

HCPCS Code A4595-SU, billed for dates of service 10/05/05, 11/08/05, 12/06/05, 01/10/06, 02/01/06, 03/10/06, 04/04/06 and 05/08/06 was denied by carrier with denial codes "97" (Payment is included in the allowance for another service. Included in global reimbursement. Reimbursement is being withheld as this procedure is considered integral to the primary procedure billed), "W9" (Unnecessary medical treatment based on peer review. Peer review obtained by the carrier Ind treatment to be medically unreasonable and/or unnecessary and documented srvc does not meet Fee Guide contained w/I appli AMA CPT/HCPCS Guide), "W1" (WC State Fee Schedule Adjust. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time.). Per Rule 134.202(b)(c)(2)(A), reimbursement for each date of service is recommended for a total amount of **$288.10 ($28.81 x 125% = $36.01 (MAR) x 8 (DOS) = $288.10.**

On 12/05/06, Requestor submitted a Withdrawal on HCPCS Code E1399-SU; for date of service 05/12/06, therefore, this service is no longer in dispute.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1, and 133.307(d)(1)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION 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 reimbursement in the amount of **$68.05.** The Division hereby **ORDERS** the Respondent 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.

Order by:

	Medical Dispute Officer	01/22/07
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.