



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

## MEDICAL FEE 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: Edward F. Wolski, M.D./Wol+Med 2436 I-35 E. South, Suite # 336 Denton, Texas 76205	MDR Tracking No.: M5-07-0361-01 (current MDR # ) M4-06-6919-01 (former MDR # )
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Rep Box # 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "We feel the carrier has violated Rule 133.304 Medical Payments and Denials, section 408.021 Entitlement to Medical Benefits and (a) TRAVELERS INSURANCE VS. MARTIN, Rule 134.600 Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, 133.304(1)(k)(q)... We feel it is time the carrier comply with the law and pay for eligible services."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits
4. Copy of preauthorization

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

Respondent's Position Summary: The position statement submitted by Texas Mutual does not address the disputed services.

Principle Documentation:

1. Response to DWC 60

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-09-05, 11-11-05 & 01-03-06	97035, 97110-59, A9150, A9999 & 99245 (Requestor withdrew the medical necessity issues)	N/A	N/A

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

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

Based on review of the disputed issues within the request, Medical Dispute Resolution has determined that **medical necessity was withdrawn**, however, this dispute also contained fee issues that will be reviewed by Medical Fee Dispute Resolution.

On 07-10-06, 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.

Services were rendered in Denton County, Texas.

CPT code 99080-73 billed for date of service 01-06-06 was denied with reason codes "W1" (Workers Compensation State Fee Schedule Adjustment), "248" (DWC-73 not properly completed or submitted in excess of the filing requirements, reimbursement denied per Rule 129.5), "W4" (No additional reimbursement allowed after review of appeal/reconsideration) and "891" (The insurance company is reducing or denying payment after reconsideration). The Respondent has not made a payment to the Requestor. Per Rule 129.5(d)(2) the documentation submitted for review by the Respondent revealed that the DWC-73 did not document a change in the work status or a substantial change in activity restrictions from the previous DWC-73 billed on 12-16-05. No reimbursement is recommended.

CPT code 90801 billed for date of service 01-30-06 was denied with reason codes "62" (Payment denied/reduced for absence of, or exceeded, pre-certification/authorization), "930" (Pre-authorization required, reimbursement denied), "W4" (No additional reimbursement allowed after review of appeal/reconsideration) and "891" (The insurance company is reducing or denying payment after reconsideration). Per Rule 134.600(h) preauthorization of a repeat psychiatric interview is required. The Respondent submitted a copy of an EOB for CPT code 90801 billed by the Requestor and reimbursed by the Respondent for date of service 12-22-05; therefore this is a repeat interview. The Requestor did not submit proof of preauthorization prior to the service being rendered; therefore, no reimbursement is recommended.

CPT code 99213 billed for date of service 02-07-06 was denied with reason codes "B15" (Payment adjusted because this procedure/services id not paid separately), "434" (Per CCI edits, the value of this procedure is included in the value of the mutually exclusive procedure), "W4" (No additional reimbursement allowed after review of appeal/reconsideration) and "891" (The insurance company is reducing or denying payment after reconsideration). Review of the CMS 1500 and EOB submitted by the Requestor revealed no other service was billed for date of service 02-07-06. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$61.63**.

CPT code 97110-59 (3 units) billed for date of service 02-08-06 was denied with reason codes "42" (Charges exceed our fee schedule or maximum allowable amount), "790" (This charge was reduced in accordance to the Texas Medical Fee Guideline), "W4" (No additional reimbursement allowed after review of appeal/reconsideration) and "891" (The insurance company is reducing or denying payment after reconsideration). The Respondent has made a payment in the amount of \$33.46. Additional reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$66.92 (1 unit @ \$33.46 x 3 units = \$100.38 minus payment of \$33.46)**.

CPT code 64999 billed for dates of service 02-08-06 and 02-27-06 was denied with reason codes "B18" (Payment denied because this procedure code/modifier was invalid on the date of service or claim submission), "893" (This code is invalid, not covered code or has been deleted from the Texas Fee Schedule), "62" (Payment denied/reduced for absence of, or exceeded, pre-certification/authorization), "930" (Pre-authorization required, reimbursement denied), "W4" (No additional reimbursement allowed after review of appeal/reconsideration) and "891" (The insurance company is reducing or denying payment after reconsideration). Per Rule 134.600(h) preauthorization is required. The Requestor did not submit proof of preauthorization of the services prior to the services being rendered; therefore, no reimbursement is recommended.

CPT code 97537-59 (2 units) billed for date of service 02-10-06 was denied with reason codes “62” (Payment denied/reduced for absence of, or exceeded, pre-certification/authorization), “930” (Pre-authorization required, reimbursement denied), “W4” (No additional reimbursement allowed after review of appeal/reconsideration) and “891” (The insurance company is reducing or denying payment after reconsideration). The Requestor submitted a copy of a preauthorization (number LAQ012421PR) authorizing physical therapy 3 x week for 4 weeks (four units) and the approved physical therapy sessions/visits are limited to a SINGLE SESSION PER DAY, FOR THE COMPENSABLE INJURY (ALL BODY AREAS); and, that session is limited to 45 minutes to 1 hour duration, no more than 4 CPT codes per session and no more than 45 minutes of cumulative timed codes was approved. Per Rule 134.600(b)(1)(B) the Requestor obtained preauthorization prior to the service being rendered; therefore, reimbursement is recommended in the amount of **\$65.02 (1 unit @ \$32.51 x 2 units)**.

CPT code 97110-59 (3 units) billed for date of service 02-10-06 was denied with reason codes “62” (Payment denied/reduced for absence of, or exceeded, pre-certification/authorization), “930” (Pre-authorization required, reimbursement denied), “W4” (No additional reimbursement allowed after review of appeal/reconsideration) and “891” (The insurance company is reducing or denying payment after reconsideration). The Requestor submitted a copy of a preauthorization (number LAQ012421PR) authorizing physical therapy 3 x week for 4 weeks (four units) and the approved physical therapy sessions/visits are limited to a SINGLE SESSION PER DAY, FOR THE COMPENSABLE INJURY (ALL BODY AREAS); and, that session is limited to 45 minutes to 1 hour duration, no more than 4 CPT codes per session and no more than 45 minutes of cumulative timed codes was approved. The Requestor has made a payment in the amount of \$33.46. Per Rule 134.600(c)(1)(B) the Requestor obtained preauthorization prior to the service being rendered; therefore, additional reimbursement is recommended in the amount of **\$66.92 (1 unit @ \$33.46 x 3 units = \$100.38 minus payment of \$33.46)**.

CPT code 97750 (3 units) billed for date of service 02-16-06 was denied with reason codes “42” (Charges exceed our fee schedule or maximum allowable amount), “790” (This charge was reduced in accordance to the Texas Medical Fee Guideline), “57” (Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day’s supply) and “863” (Documentation does not support the need for more than 30 minutes of time), “W4” (No additional reimbursement allowed after review of appeal/reconsideration) and “891” (The insurance company is reducing or denying payment after reconsideration). The Respondent has made a payment in the amount of \$71.02. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation for review which supports the service billed. Additional reimbursement is recommended in the amount of **\$35.51 (1 unit @ \$35.51 x 3 = \$106.53 minus payment of \$71.02)**.

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

28 Texas Administrative Code Sec. §134.1, §134.600, §129.5 and §134.202  
Texas Labor Code, Sec. §413.031 and §413.011 (a-d)

**PART VII: DIVISION FINDINGS 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 reimbursement in the amount of \$296.00. 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.

Findings and Order by:

06-11-07

Authorized Signature

Medical Dispute Resolution Officer

Date of Findings and 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.**