



**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL NECESSITY DISPUTE RESOLUTION FINDINGS AND DECISION**

**PART I: GENERAL INFORMATION**

Requestor's Name and Address:  Horizon Health 6666 Harwin, Suite 430 Houston, Texas 77036	MFDR Tracking #: M5-08-0103-01
	Previous Tracking #: M4-04-7915-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  PACIFIC EMPLOYERS INSURANCE CO Box 15	Date of Injury:
	Employer Name:
	Insurance Carrier #:

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

Requestor's Position Summary: "We are requesting the above file to be reviewed by an IRO."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$19,226.14\*
3. CMS 1500s
4. EOBs

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION**

No Position Summary was received from the Respondent.

**PART IV: SUMMARY OF FINDINGS – MEDICAL NECESSITY ISSUES**

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
4-1-03 – 8-29-03	99213 (49 DOS x \$48.00) + (12 DOS x \$65.21)	U, V	1a	\$3,134.52
4-1-03 – 9-12-03	97150 (286 units x \$27.00) + (102 units x \$23.61)		1a	\$10,130.22
4-1-03 – 9-12-03	97112 (45 units x \$35.00) [5 @ <MAR] + (12 units x \$36.68)		1a, 1b	\$2,015.16
4-14-03 – 8-11-03	99080-73 (5 reports x \$15.00)		3	\$75.00
9-3-03 – 9-12-03	99212 (6 DOS x \$46.41)		1a	\$278.46
4-14-03	99214		2	\$0.00
<b>Total Due:</b>				\$15,633.36

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent. Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, sets out the reimbursement guidelines for dates of service 8-4-03 – 9-12-03.

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule §134.201 titled (Medical Fee Guideline For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, sets out reimbursement guidelines for dates of service 4-1-03 – 7-31-03.

\*In a fax dated 7-1-08 the Requestor sent a revised Table of Disputed Services. This revised Table will be used for this Review.

1. The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. Per Rule 134.202(d)(2) the amount due the Requestor for these items is \$15,633.36.
  - a. Per review of Box 32 on CMS-1500, zip code 77036 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.
  - b. Per Rule 134.202(d) "reimbursement shall be the least of the (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." The lesser of these amounts was the usual and customary charge.
2. The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on CPT Code 99214 for date of service 4-14-03. No reimbursement is recommended.
3. Regarding CPT Code 99080-73: Recommend reimbursement per Rule 129.5(i).

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311  
28 Texas Administrative Code Sections 129.5, eff 7-16-00, 133.308 eff. 1-2-03, 134.1 eff. 5-16-02, 134.201 eff. 4-1-96, 134.202, Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement and is entitled to a refund of the IRO fee (\$460.00) for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$15,633.36 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

#### **DECISION:**

Donna D. Auby  
Medical Fee Dispute Resolution Officer

#### **ORDER:**

Martha Luevano  
Medical Fee Dispute Resolution Manager

Authorized Signature

Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**