MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Edward F. Wolski, MD 2436 S. I-35 E. Suite 336 Denton, TX 76205	MDR Tracking No.: M4-05-0052-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 American Home Assurance Co.	Date of Injury: Employer's Name: Wal Mart Stores Inc. Insurance Carrier's No.: C3263262

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	**To**			
09/02/03	**10/01/03**	**SEE PAGE 2, DETAILS**		

PART III: REQUESTOR'S POSITION SUMMARY

The carrier denied payment using PEC-F on 9/2/03, 9/4/03, 9/6/03, 9/13/03, 9/20/03, and 10/1/03. There is a MAR assigned to all the services except 9/20/03 but the carrier failed to pay this amount. By using PEC-F the carrier is stating that they are referencing the fee guidelines to make this reduction. Because they failed to pay according to the fee guidelines, it is inappropriate to use PEC-F. The carrier has used the incorrect PEC Per Rule 133.304 (c)…

For date of service 9/9/03 the carrier failed to respond to our initial billing. We feel they have failed to comply with Rule 133.304…

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier supplied missing EOBs, which include all EOBs processed upon reconsideration. The carrier also provided documentation in the form of EOBs showing payments made for dates of service 9/2/03 (99205) and 9/9/03 (97113) where these services in dispute were paid in full.

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

CPT code 97139 for dates of service 9/2/03, 9/4/03, & 9/6/03 was denied after reconsideration for incorrect or invalid modifier per EOBs. The requestor has provided HCFAs submitted for reconsideration without any modifiers. The respondent did not supply HCFAs that showed modifiers; therefore, payment recommended per Medicare Fee schedule plus 125% x 3 dates of service.

CPT code 97110 for dates of service 9/2/03, 9/4/03, 9/6/03, 9/9/03, 9/13/03, & 10/01/03 was denied after reconsideration as the value of this procedure is included in the value of the comprehensive procedure per EOBs. Furthermore, EOBs state "Per NCCI edits, a charge was made for a "separate procedure" which is an integral part of a total service performed at the same time." Per Rule 133.304 (c), "At the time an insurance carrier makes or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the carrier's actions. A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases…does not satisfy the requirements of this section." The carrier does not specify the "separate or more comprehensive procedure" on the EOB. However, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the

State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

CPT code 97799 for date of service 9/20/03 was denied after reconsideration as the value of this procedure is included in the value of the comprehensive procedure per EOBs. Furthermore, EOBs state "Per Texas Medicare NCCI edits, a charge was made for a "separate procedure" which is an integral part of a total service performed at the same time."

Per Rule 133.307 (g)(3)(D)- "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement…" The requestor has supplied several EOBs for review, but only one EOB demonstrates the actual CPT code being sought for reimbursement in this dispute was actually reimbursed by one carrier. The documentation to support the service indicates a form of aquatic therapy being rendered, but several of the redacted EOBs also have CPT code 97113 listed, which is aquatic therapy, or other unlisted CPT codes; therefore, documentation submitted does not justify a fair and reasonable rate of reimbursement.

CPT code 99205 for date of service 9/2/03 and CPT code 97113 for date of service 9/9/03 were previously reimbursed by the insurance carrier per EOBs supplied by the respondent, therefore, no dispute exists for these services.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
9/2/2003	99205	$196.30	$0.00/pd.				
9/2/2003	97139/x 2	$36.52	$36.52				
9/2/2003	97110	$65.28	$0.00				
9/4/2003	97139/x2	$36.52	$36.52				
9/4/2003	97110	$65.28	$0.00				
9/6/2003	97139/x2	$36.52	$36.52				
9/6/2003	97110	$65.28	$0.00				
9/9/2003	97110	$65.28	$0.00				
9/9/2003	97113/x2	$69.26	$0.00/pd.				
9/13/2003	97110	$65.28	$0.00				
9/20/2003	97799	$47.00	$0.00				
10/1/2003	97110	$65.28	$0.00				
				Total Left Column:			$813.80
				Total Amount Due:			$109.56

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $109.56. 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 20-days of receipt of this Order.

Ordered by:

	Benita Diaz	05-31-05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____________. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

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

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: ____ Date: ________________________