MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Integra Specialty Group, P.A. 517 N. Carrier Pkwy., Suite G Grand Prairie TX 75050	MDR Tracking No.: M4-05-0257-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 42 Irving ISD c/o Harris & Harris 5300 Bee Cave Rd., Bldg III, Suite 200 Austin TX 78746	Date of Injury: Employer's Name: Irving ISD Insurance Carrier's No.: IS101777

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			
9/11/03	**2/14/04**	**99213, 99214, 97012, 97032, 97110, 97140, 95851, 95833, 96004, 97750-MT, 99080-73**	**$3,311.79**	**$2,609.13**

PART III: REQUESTOR'S POSITION SUMMARY

9/25/04: "…The carrier denied multiple services with "A" – Pre-Authorization not obtained…specific response to the carrier's denial is that pre-authorization was not required for the CPT codes that the carrier denied with the "A" code."

Additional letter sent to Compliance and Practice dated 9/7/04.

PART IV: RESPONDENT'S POSITION SUMMARY

9/21/04: Response to MDR request was received from the respondent which stated to "Please direct all future correspondence regarding this Medical Dispute matter to…Harris & Harris."

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

- A TWCC-60 request was received by Medical Dispute Resolution (MDR) on 9/9/04. The requestor, is seeking reimbursement for treatment/services rendered to the claimant that were denied with "F", defined, "Reduced According to Fee Guideline" / "The value of this procedure is included in the value of the comprehensive procedure" and "A" – defined, "Pre-Authorization Not Obtained," / "Treatment not Authorized."
- The respondent did not submit further explanations to MDR.
- The denials of "F" and "A" both revealed conflicting descriptions of the CPT codes. The dates of service (DOS) are all post 8/1/03, therefore are under rule 134.202, which is Medicare pricing. The treatment/services denied with "F" is not reviewed 'per value of the comprehensive procedure.' The treatment/services denied with "A" do not 'require preauthorization' according to 134.600 (h). Therefore, MDR will review the outstanding DOS as fee issues.
  a) The following CPT Codes, according to rule 134.202, have been supported with convincing evidence through S.O.A.P. notes or reports that treatment/services were rendered for DOS 9/11/03 through 2/14/04. Therefore, reimbursement is recommended as follows.

1) 99214 x (1 DOS @ $71.00) = **$71.00**
2) 99213 x (9 DOS @ $66.19) = **$595.71**
3) 97012 x (4 DOS @ $18.90) = **$75.60**
4) 97032 x (1 DOS @ $20.20) = **$20.20**
5) 97124 x (11 DOS @ $28.44) = **$312.84**
6) 97140 x (10 DOS @ $34.05) = **$340.50**
7) 95851 x (2 units @ $26.40) = **$52.80**
8) 95833 x (2 units @ $44.99) = **$89.98**
9) 96004 x (1 DOS @ $ 143.95) = **$143.95**
10) 96004 x (1 DOS @ $ 152.75) = **$152.75 (per 2004 guideline)**
11) 97750-MT x (20 units @ $36.94) = **$738.80**

TOTAL: $2,594.13

b) Report, CPT code 99080-73 is reimbursed at $15.00 each according to rule 133.106(f)(1). Convincing evidence supports treatment/services rendered, therefore, reimbursement due for DOS 2/14/04 @ **$15.00**.

c) The CPT Code, 97110 for all DOS are not recommended for reimbursement. Review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section 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 has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy.

PART VI: 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 $2,609.13. 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.

	James Schneider, Manager	**5/19/05**
Authorized Signature	Typed Name	Date Signed
		5/19/05
Authorized Signature	Name	Date of Order

PART VII: 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, PO Box 17787, 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 VIII: 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: _____