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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

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

Requestor's Name and Address: Medpro Clinics 7447 Harwin, Ste. 190 Houston, TX 77036	MDR Tracking No.: M4-05-0514-01 (formerly M5-04-3864-01) Claim No.: Injured Employee's Name:
Respondent's Name and Address: Fort Bend ISD C/o Harris & Harris Rep Box #: 42	Date of Injury: Employer's Name: Fort Bend ISD Insurance Carrier's No.: FB201321

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor did not submit a position summary; however, including in the dispute package is a letter to Ward North America that states in part, "…This is a repeat of a pattern of denial by the untrained and inexperienced Fair Isaac's staff. Otherwise they would know that this procedure is not subject to peer review…"

Principle Documentation:

1. Requestor's letter to auditing company
2. TWCC 60/Table of Disputed Service
3. HCFA-1500
4. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "…Respondent has reviewed the Provider's information, and is in the process of reevaluating the bills made the basis of this dispute…"

Principle Documentation: 1.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
05/24/04	V	99455-VR – Review of MMI/IR Report from another doctor	1	$50.00
TOTAL DUE				$50.00

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

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

1. CPT Code 99455-VR for date of service 05/24/04 denied as "V – Unnecessary treatment (w peer review). This CPT Code with the attached modifier "VR" indicates the treating doctor is required by the Division to review of the certification of MMI and assignment of IR performed by another doctor and is not subject to the denial of unnecessary medical treatment with or without a peer review. Therefore, per Rule 134.202(e)(6)(F) reimbursement in the amount of $50.00 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202(e)(6)(F)

PART VII: DIVISION DECISION 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 additional reimbursement **in the amount of $50.00.**

Ordered by:

	Marguerite Foster	March 10, 2006
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.