



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: Texas Imaging & Diagnostic Center 3840 W. NW Hwy. #400 Dallas TX 75220	MDR Tracking No.:	M4-05-0901-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name and Address: Texas Mutual Ins. Co. Rep Box #: 54	Date of Injury:	
	Employer's Name:	StaffWorks, Inc.
	Insurance Carrier's No.:	99C0000311998

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's and HCFA's
4. Lumbar Myelogram / Procedure reports / letter of medical necessity

Position Summary: "...We were not reimbursed for the tomography...used...to get different views...oblique and 3-dimensional reconstruction to check the alignment for a better view of the vertebral foramen and to get a better perspective of the bone height. Also, the Contrast (A4644), Supplies (99070-ST) and Recovery Room (99499). We resubmitted this claim with a copy of an IRO decision from a different case...along with published articles proving the need for CT reconstructions. In our dispute, I am also including a letter from our nurse listing the necessary requirements and how we meet them, copies of our supply sheets...EOB's from various insurance companies...Per TWCC MFG...we are requesting to be reimbursed according to TWCC MFG...."

On 12/15/03, CPT code 76375 -Computerized Tomography was withdrawn from MDR. Therefore, no longer a part of dispute.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Respondent's response to MDR.

Position Summary: "The Texas Mutual...received a TWCC-60...Pursuant to Commission rule 133.307(e)(2) sections (A) through (C) and 133.307 (e)(3)...completed TWCC-60 and related items. As the respondent...the carrier further asserts it has properly completed Parts II, III, V and VI...Attached items include...Completed TWCC-60...list of additional providers...A list of all providers that participated in the review..."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
11/12/02 & 11/14/02	G/M	99070-ST Sterile Tray	1. (a)	\$237.11
11/12/02 & 11/14/02	M	A4644- non-ionic low contrast material	1. (b)	\$00.00
11/12/02	G	99455-RR Postoperative monitoring	1. (c)	\$119.00

TOTAL DUE

\$356.11

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

1. Section 413.011 (a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.201 titled (Medical Fee Guideline For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, set out reimbursement guidelines.

- This dispute is related to lack of full reimbursement for treatment/services rendered with a Lumbar Myelogram and Fluoroscopically Guided Epidural Blood Patch on the dates of service (DOS) mentioned above.
- Review of the dispute reveals the following:

(a) CPT code 99070-ST: Denial codes were: DOS 11/12/02, "G- Reimbursement for this procedure is included in the basic allowance for another procedure" and DOS 11/14/02, "M – The reimbursement for this service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with the Labor Code 413.011(B)."

** No reimbursement was made toward DOS 11/12/02.

* Reimbursement of \$50.00 was made for DOS 11/14/02.

The requestor billed \$237.11 for DOS 11/12/02 and was paid \$0.00 based upon a 'global' denial. Per MFG/ Surgery Ground Rule (V)(B), 99070-ST is reimbursable. The Respondent did not dispute amount as 'fair and reasonable,' therefore reimbursement recommend as billed: **\$237.11.

* For DOS 11/14/02, per the MFG, this CPT code does not have a MAR, therefore reimbursement is based upon the DOP provided and 'fair and reasonable' reimbursement. According to the Surgery Ground Rule V, 'Sterile trays include all supplies...needles...and reimbursement is the lesser of the doctor's usual charge or fair and reasonable.' Redacted EOBs do not support the criteria for usual and customary billing as provided by the Requestor. The Respondent reimbursed DOS 11/14/02 based upon a 'fair and reasonable' amount according to a 'developed methodology.' Therefore, no additional reimbursement is recommended for DOS 11/14/02.

(b) CPT code A4644: Denial code was "M- the reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B)."

Reimbursement of for the 2 DOS was \$25.00 for each date. The Respondent stated this amount was according to a developed methodology for a 'fair and reasonable' reimbursement. Per the MFG / Radiology/Nuclear MGR(II)(A), supply of non-ionics are billed under this CPT code. This CPT code requires DOP, and is based upon 'fair and reasonable' reimbursement. Redacted EOBs do not support the criteria for usual and customary billing as provided by the Requestor, therefore no additional reimbursement is recommended.

(c) CPT code 99455-RR: Denial code was "G- Reimbursement for this procedure is included in the basic allowance for another procedure" Reimbursement of for the DOS was \$00.00 Per the MFG / Surgery Ground Rule (V)(B)(3), postoperative monitoring is reimbursed hourly. According to the HCFA, one hour of time was billed. According to the diagnostic report, 'time' was verified. The Respondent did not dispute amount billed as fair and reasonable. Reimbursement of **\$119.00** is recommended.

Therefore, it is the conclusion of MDR that reimbursement in the amount of \$356.11 is due.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. § 413.011(a-d)
28 Texas Administrative Code Sec. § 134.1
MFG / Surgery Ground Rule (V)(B)
MFG / Radiology/Nuclear MGR(II)(A)

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 \$356.11.**

Ordered by:

Authorized Signature

Typed Name

2 / 8 / 06

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.