**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

| | |
|---|---|
| Requestors Name and Address:<br>Eric A. VanderWerff, D. C.<br>615 N. O'Connor Rd., Suite 12<br>Irving, Texas 75061 | MDR Tracking No.: M4-05-0912-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name:<br>American Home Assurance Company, Box 19 | Date of Injury:<br>Employer's Name: WAL MART STORES INC<br>Insurance Carrier's No.: C4235011 |

## PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "Millennium Chiropractic is requesting fee reimbursement for the above listed date of service for the following reasons: per TWCC Rule 134.202 (c)(6) for products and services for which CMS or the Division does not establish a relative value unit and/or a payment amount the Respondent shall assign a relative value studies, published Commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

## PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "This firm has been retained to represent the Carrier in the above-referenced matter…Enclosed please find documents responsive to this issue for your review…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

## 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) |
|---|---|---|---|---|
| 5-28-04 | F-770 | 95927-TC-59 | 1 | $0.00 |
| 5-28-04 | F | 95903-TC ($48.15 x 6 units - $288.90) | 2 | $0.00 |
| 5-28-04 | F | 95926-TC-59 ($48.03 x 2 units - $48.03) | 3 | $48.03 |
| 5-28-04 | F | 95934-TC ($11.86 x 2 units - $17.80) | 4 | $0.00 |
| 5-28-04 | S, 350 | 95904-TC ($48.65 x 2 units - $97.30) | 5 | $0.00 |
| | Total Due | | | $48.03 |

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

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

On 10-18-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

1. The Respondent denied these services as "F, 770-No allowance has been recommended for this procedure/service/supply." The reconsideration response addresses the issue of documentation and payment for one unit was rescinded. No medical documentation was provided to the Division in order to authenticate the services. No additional reimbursement recommended.

2. The Respondent denied these services as "F-Fee Guideline MAR reduction." The reconsideration response states "all six units are documented and paid at the fullest allowable amount." The Respondent has reimbursed $288.90. No additional reimbursement is recommended.

3. The Respondent denied these services as "F-Fee Guideline MAR reduction." The reconsideration response states "Proper use of 95926 is one unit per entire study." The Descriptor for this CPT code states, "tests of lower limbs." Therefore, two units are allowed. The Respondent has reimbursed $48.03. Additional reimbursement of $48.03 for 1 unit per the 2002 MFG is recommended.

4. The Respondent denied these services as "F-Fee Guideline MAR reduction." The reconsideration response states "Code 95934 is subject to the bilateral rule, and a bilateral procedure is valued at 1.5 units. 1.5 units 95934 were allowed and paid at maximum allowable amount." The Requestor did not bill with the "50" modifier. The Respondent has reimbursed $17.80. No additional reimbursement is recommended.

5. The Respondent denied these services as "S-350—Based on the submitted documentation from the provider, we recommend an additional allowance be made." The reconsideration response states "2 units 95904 are paid at the maximum allowed amount." The Respondent has reimbursed $97.30. No additional reimbursement recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 134.1, 134.202

**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 $48.03. 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 30-days of receipt of this Order.

**Ordered by:**

| | Donna Auby, Medical Dispute Officer | 11-03-06 |
|---|---|---|
| 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.**