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: Ryan N. Potter, M.D. 1415 Third Street, Suite 303 Corpus Christi, Texas 78404	MDR Tracking No.: M4-05-1157-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American International South Insurance Company C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Coastal Drilling Land Company Insurance Carrier's No.: 077072907

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Rationale A: Preauthorization was obtained prior to services rendered. Fluoroscopic guidance for needle placement is separately reimbursable per Medicare reimbursement guidelines."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Preauthoriztion Approval Letter dated 12/04/03, authorization approval # 014050002, approving Lumbar epidural steroid injection with fluoroscopy and sedation as medically necessary

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Provider has requested dispute resolution regarding charges under CPT code 76005 for date of service 12/10/03. Provider had billed the carrier for a large number of services under that date of service. Several of the charges including the charges under CPT 76005 where included in the reimbursement for to other procedures..."

Principle Documentation:
1. Respondent's position summary
2. TWCC 60/Table of Disputed Services
3. Explanation of Benefits

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)
12/10/03	G	76005	1	$89.69
TOTAL DUE				$89.69

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. Code 76005 for date of service 12/10/03 was denied "G". Carrier reimbursed the Requestor $00.00. Per Rule 134.600(b)(1)(B), "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury:…only when the following situations occur:…preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the heath care." Per Rule 133.301(a), the Carrier shall not retrospectively review treatments/services for which preauthorization has been obtained. Information provided by the Requestor indicates that preauthorization was obtained on 12/04/03 under preauthorization number 014050002. According to the CMS CCI edits, CPT code 76005 is not considered a component procedure of CPT codes 62311 and 99141, therefore, separate payment for the services billed are considered justifiable and unbundling is not an issue. Per Rule 134.202,

reimbursement shall be according to Medicare plus 125%. Medicare pricing is $89.69 (71.75 x 125% = $89.69). Therefore, reimbursement in the amount of $89.69 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
28 Texas Administrative Code Sec. §133.301(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 **$89.69**. 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:

Authorized Signature	Typed Name	01/27/06 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.