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: Advanced Neurological P.O. Box 1895 Deer Park, TX 77536	MDR Tracking No.: M4-05-1493-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Indemnity Insurance Co. C/o ACE USA/ESIS Box 15	Date of Injury: Employer's Name: Waste Management, Inc. Insurance Carrier's No.: 003000100974WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…Please note that the carrier has denied these services as 'global-included in another service charged on this same day.' This is incorrect in that per fee guidelines and other carriers, these services are not considered global and are usually paid for. The carrier has paid for theses services in the past. Additionally, you should note that the TWCC designated doctor ordered these services…"

Principle Documentation:

1. Requestor's position summary
2. HCFA 1500's
3. EOB's
4. Medical Records

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to the Request for Dispute Resolution or additional information submitted by the Requestor.

Principle Documentation:

1. N/A

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/23/03	99244 – Office Consultation	1	$174.85
12/23/03	99358 - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care	2	ICIC
12/23/03	95869 – Muscle Test	3	$0.00

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, sets out reimbursement guidelines.

This dispute relates to procedure codes 99244, 99358 and 95869, that were denied as "G – Correct Coding Initiative Bundle Guidelines indicate this code is a comprehensive component of another code on the same day. According to the Center for Medicare Correct Coding Initiative (CCI) Edits CPT Code 95831 is considered to be a component procedure of CPT Code 99244; CPT Code 95869 is considered to be a component procedure of 95861. According to the Medicare Fee Schedule CPT Code 99358 does not have a MAR.

1. CPT Code 99244 – The MAR for this CPT code is $203.85. The insurance carrier incorrectly paid $29.00 for the component procedure code (95831); therefore, this amount will be deducted from the MAR amount of CPT code

99244. Per Rule 134.202(b) and (c)(1) the requestor has submitted medical records to support the services rendered as billed. Reimbursement in the amount of $174.85 ($203.85 - $29.00) is recommended.

2. CPT Code 99358 – The Carrier incorrectly denied this code. According to CCI edits this code is not considered a component of another code billed on the same day. Per Rule 134.202(c)(6), for services for which CMS or the Division does not establish a relative value unit or a payment amount the carrier shall assign a relative value. Therefore, reimbursement is recommended and the Carrier shall assigned a value.

3. CPT Code 95869 – The MAR for this CPT Code is $35.21. According to CCI edits this code is considered to be a component of procedure code 95861, which was performed on the same day and reimbursed by the Carrier; therefore, additional reimbursement is not recommended.

Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of **$175.85 plus the assigned value of code 99358** is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. 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 **$175.85 plus the assigned value of Code 99358**. 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:

	Marguerite Foster	January 5, 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.