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: First Rio Valley Medical, P.A. 620 Paredes Line Rd. Brownsville, TX 78521	MDR Tracking No.: M4-05-1644-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TML Intergovernmental Risk Pool Rep Box # 19	Date of Injury: Employer's Name: City of Brownsville Insurance Carrier's No.: T120200070633 4NLG

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Requestor's position statement
2. Form 60
3. EOB's
4. CMS 1500 forms

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Position Statement states in part… "It is the carrier's position that no additional reimbursement is due and that it has paid all reasonable, necessary and related medical charges in accordance with the Statute, Rules and Medical Fee Guidelines."

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)
06/21/02, 7/1/02,08/26/02,08/28/02,09/05/02, 09/09/02, 09/11/02, 09/23/02	F	97022	1	$160.00
09/26/02	K,F	95900-27, 95935-27, 95904-27	2	$417.20
TOTAL DUE				$577.20

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

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

The requestor has submitted a letter of withdrawal for CPT code 95925 for date of service 9/26/02; therefore, it will not be reviewed.

1. CPT Code 97022-22 (8 units total) for dates of service 7/1/02 through 9/23/02 were denied as "F". Per the 1996 Medical Fee Guideline, Medical Ground Rule (I)(C)(7) sterile whirlpool shall be reimbursed at $40.00. The respondent reimbursed the requestor $20.00 per unit; therefore, additional reimbursement in the amount of $160.00 ($40.00 x 8= $320-$160 carrier payment) is recommended.

2. CPT codes 95900-27, 95935-27, & 95904-27 were denied as K-not appropriate healthcare provider & F-fee guideline mar reduction. The carrier does not reference any rules nor does the carrier elaborate on their denial as required per Rule 133.304 (c). In addition, CPT code 95935-27 was denied with F-Per 1996 TWCC MFG pg. 42 H/F reflex paid per study, not per nerve. The requestor is billing with modifier 27 for the technical component, which is the interpretation of the nerve conduction study. According to the report and the CMS 1500 form submitted by the requestor for 95900-27 (motor nerves) both right and left peroneal and tibial nerves were tested, therefore, four units will be reimbursed as such:

   (a) $64.00 (mar for 95900) x 70% (for technical component)= $44.80 x 4 units= $179.20.

According to the report and the CMS 1500 form 95904-27 (sensory nerves) both left and right sural nerves were tested, therefore, two units will be reimbursed as such:

   (b) $64.00 (mar for 95904) x 70% (for technical component)= $44.80 x 2 units= $89.60

According to the CMS 1500 form 95935-27 (H/F reflex studies) six units were billed. The 1996 Medical Fee Guidelines Medicine Ground Rules IV. B. 2. a. Reimbursement shall be per study, not per nerve. Per the report, F waves and H waves were performed bilaterally, therefore, only four units will be reimbursed as such:

   (c) $53.00 (mar for 95935) x 70% (for technical component)= $37.10 x 4 units= $148.40.

Total recommended reimbursement is $577.20.

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. §133.304

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 $577.20.**

Ordered by:

Authorized Signature	Benita Diaz 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.