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: South Coast Spine & Rehabilitation Center, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M4-05-2534-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Old Republic Insurance Company Box 02	Date of Injury: Employer's Name: Insurance Carrier's No.: 0R04EG01980001

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60

POSITION SUMMARY: "This dispute is a medical fee dispute and not a medical necessity dispute. Medical necessity is not an issue in a medical fee dispute according to rule 133.307(a). Therefore, we are entitled to submit this request".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "Dr. Howell billed office visits (99213) in addition to physical therapy codes for the same date of service. The dates of service were initially denied as the documentation did not meet the criteria for modifier 25 per the CMS Trailblazer Modifier Overview, page 8 (attached), nor the NCCI edits, page 22 (attached). Medicare is specific that the office visit must be a significant separate identifiable evaluation and management service. The Requestor has not initially, nor with the appeal supplied any documentation to comply with the Medicare nor the NCCI requirements showing that the office visit was a separate and distinct service from the Physical Therapy for the respective dates of service".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08-12-04 to 09-07-04	99213-25 ($61.98 X 10 DOS)	(1)	$619.80

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

(1) CPT code 99213-25 was denied by the carrier as "reimbursement denied as documentation does not meet the criteria for modifier 25 per the CMS Trailblazer modifier overview pg 8 and/or the CCI edits pg 22". Per Ingenix modifier 25 is used to distinguish a "significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service". Review of office notes submitted by the Requestor indicated there were not two Evaluation and Management services performed on the dates of service in dispute. Reimbursement is recommended in the amount listed above per Rule 134.202.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202

PART VII: DIVISION FINDINGS 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 reimbursement in the amount of $619.80. 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.

Order by:

		04-25-06
Authorized Signature		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.