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, P.A. 620 Paredes Line Rd. Brownsville TX 78521	MDR Tracking No.: M4-05-2951-01 (Previous M4-05-3964-01 or M5-06-1389) Claim No.: Injured Employee's Name:
Respondent's Name and Address: TML Intergovernmental Risk Pool Rep Box #: 13	Date of Injury: Employer's Name: City of Brownsville Insurance Carrier's No.: T120400096072

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. TWCC-60
2. EOB's and CMS-1500's
3. Documentation for services rendered
4. Documentation to support the Requestors request for MDR

Position Summary: "We are…notifying the MDR…(we) were unable to agree on issues…We have complied with the above rule and we are entitled to submit a medical fee dispute."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Respondent's response to MDR.

Position Summary: "…This medical dispute concerns treatment the requestor provided to the claimant between 8/13/04 and 9/24/04. The carrier maintains that it has reimbursed the requestor for all reasonable and necessary treatment that is RELATED to the compensable injury…"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
8/13/04	F / R	99213 – office visit	1.	$61.98
9/24/04	F / R	99080-73 RTW Report		$15.00
TOTAL DUE				$76.98

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

1. 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.
(MDR = Medical Dispute Resolution, DOS = Date(s) of Service, EOB = Explanation of Benefits)

- This dispute is related to lack of reimbursement for an office visit on 8/13/04 and a RTW report provided on 9/24/04.
- The CPT codes were denied per the EOB's: 1st;- "F – Fee Guideline MAR Reduction," 2nd- "R- Extent of injury"- "150- Denied per Insurance Carrier decision." The Respondent suggested reimbursed of $61.98 on the 1st EOB. A call was placed to the audit company. Lisa verified that no payment went out. The 2nd EOB resulted in denial of 'R' with $00.00 reimbursement suggested.

- The Requestor billed for Diagnosis Codes: 840 Sprain & Strain-Shoulder; and 726.1, Rotator Cuff Shoulder Injury."

- A BRC agreement was resolved on 8/11/05 with the following statements: 1) "The Parties agreed that the ___ compensable injury extends to include a right shoulder strain or sprain. The ___ compensable injury *does not extend* to include any right shoulder rotator cuff tears. 2) The Parties *agreed that the claimant did not sustain* an intervening injury to the right shoulder on June 15, 2004. 3) The Parties agreed that the claimant was disabled from June 8, 2004 through August 8, 2004…"

- As a result of the BRC, the Respondent did not respond to the Requestor with any additional review for these DOS.

- According to the daily S.O.A.P. report for 8/13/04, the following has been reviewed in part: "This evaluation is done today to determine if the treatment that has been provided…has been beneficial in reducing…pain levels, increasing his ROM, and to discuss his work. Also, to review if there are any changes in function and activities of daily living…will be returned back to work full-time with restrictions…Since he has responded well to care I believe his diagnosis was a sprain/strain of his right shoulder.

- According to the TWCC-73 return to work status report dated 9/24/04, the IW was returned to work on "9/26/04 without restrictions."

- The documentation presented for review supported the treatment for the sprain/strain of the shoulder as the main diagnosis and the support for the RTW form. Therefore, according to the BRC agreement, reimbursement is recommended per fee guideline MAR, Rule 134.202 as follows:

CPT code/descript	MAR	UNITS	Due
99213 – office visit	($49.58 x 125%=)	1 unit	$61.98
99080-73 RTW report			$15.00
		TOTAL	$76.98

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 $76.98.**

Ordered by:

Authorized Signature	Typed Name	4 / 21 / 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.