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: ( ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Bart B. Key, DC 149 Greens Rd. East Houston TX 77060	MDR Tracking No.: M4-05-3184-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Box: 19 American Home Assurance Co.	Date of Injury: Employer's Name: Covenant House Texas Insurance Carrier's No.: 077089365

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documents:
1. TWCC-60
2. EOB's
3. HCFA's
4. SOAP Notes/Reports/Evaluations

Position Summary: (Requestor first submitted the disputed dates of service (DOS) to Medical Dispute Resolution (MDR) on 8/16/04. MDR placed file in non-jurisdiction area due to the denial of 'E- extent issues.' Requestor submitted a follow-up letter on 12/21/04 with a time line of events to MDR to explaining that the file has only fee issues, 'extent is not the issue.' Upon review, MDR re-entered the file into the active system.

The following is a short position summary of that letter dated 12/21/04): "…On 3/19/04…carrier listed nature of injury left knee, ankle and hip…As the "requestor" we timely filed request for MDR…Denial prior to filing MDR on 8/16/04 was always "unrelated to compensable injury"…The local field office will not allow us to schedule a BRC on compensability as the carrier has never disputed the ankle or knee…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documents:
1. Respondent's response's dated 9/8/04 and 9/24/04
2. TWCC-60
3. Peer Review
4. Activity Notes

Position Summary: "…The dispute has been marked as 'fee reimbursement' only but the dispute is also a 'retrospective medical necessity' dispute…The Carrier is disputing whether the services performed were necessary in relation to the compensable injury…A review of the medical information indicates the treatment provided would not be medically necessary or related to the injury of 5/11/03 involving a limited sprain at the shoulder, left knee and left ankle…Carrier maintains its position as outlined in the original response…Dr. Brownhill's peer review (8/2/04,… History…while working…she fell. She states that she injured both shoulders, her left knee, her left ankle and left hip)…"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due
2/10/04, 2/12/04, 3/11/04	99213- office visit x 3	1	$144.00
2/27/04, 3/1/04, 3/17/04 & 3/19/04	99212 – office visit x 4	1	$128.00

2/10/04, 2/12/04, 2/27/04, 3/1/04	97530 – therapeutic activities x 4	1	$140.00
2/10/04, 2/12/04, 2/27/04, 3/1/04, 3/11/04, 3/17/04, 3/19/04	97110 (2 units ea) – therapeutic procedures x 7	1	$490.00
2/10/04, 2/12/04, 2/27/04, 3/1/04	97032 – electrical stimulation x 4	1	$88.00
		Total due:	$990.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.201 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.

This dispute relates to office visits and therapy rendered between dates 2/10/04 - 3/19/04. All treatment/services were denied as 'E'- unrelated to the compensable injury.

1) Documentation submitted by the Requestor and Respondent confirmed the compensable body areas of the left knee, left ankle and left hip.
The documentation received for review including SOAP notes, Peer Reviews and HCFA's all confirmed treatment rendered to the compensable body areas.
According to Rule 133.307 (j)(2), the Respondent shall address only those denial reasons presented to the requestor prior to the date the initial request for MDR is filed.
Therefore, it is the conclusion of the Medical Review Division that reimbursement per MAR of the 1996 Medical Fee Guideline in the amount of $990.00 is due the Requestor for the DOS 2/10/04 through 3/19/04.

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. 133.307 (j)(2)
1996 Medical Fee Guideline MAR
Medicine Guideline Ground Rule (I)(A)(10)

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 $990.00. 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	10 / 25 / 05 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.