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 and Rehabilitation, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M4-05-3976-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Travelers Indemnity Company Rep Box # 05	Date of Injury: Employer's Name: Insurance Carrier's No.: 478CBB8T8964

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package.
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

No response was submitted by the Respondent.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
06-07-04	99213	(1-3)	$0.00
06-14-04	99213	(1-3)	$0.00
06-17-04	99213	(1-3)	$0.00
06-21-04	99213	(1-3)	$0.00

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

(1) Per CMS 1500's submitted by the Requestor CPT code 99213 was originally billed with modifier "QB". The Requestor submitted reconsideration CMS 1500s with modifier "QB" and "25". Per Rule 133.304(k) if the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request the insurance carrier to reconsider its action. The sender shall submit the request for reconsideration clearly marked "REQUEST FOR RECONSIDERATION".

(2) A review of the reconsideration CMS 1500's submitted by the Requestor revealed that the modifier for CPT code 99213 was changed from "QB" to "25". It is unclear if an original "amended" bill with modifier "25" was submitted to the carrier for consideration, therefore, this is not a proper request for medical dispute resolution per Rule 133.305.

(3) The above requirements were not met by the Requestor, therefore, no further review is warranted.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.304(k) and 133.305

PART VII: DIVISION FINDINGS AND DECISION

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 not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

		04-05-06
Authorized Signature		Date of Findings and Decision

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.