



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 & Rehab Center, P.A. 620 Paredes Line Rd. Brownsville TX 78521	MDR Tracking No.:	M4-05-3989-01
	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.:	T120400099439

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

- Principle Documentation:
1. TWCC-60
 2. EOB's and HCFA's / documentation of sending to IC
 3. SOAP notes / Exam / Report

Position Summary: "...We are asking "the Division" to evaluate this request...This is a medical fee dispute..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

- Principle Documentation:
1. Respondent's response to MDR.
 2. Copy of the TWCC-60

Position Summary: "...Provider is seeking reimbursement...Provider submitted medical bills on December 13, 2004 marked as "Request for Reconsideration", but Self-Insured did not have any record of the original medical bill being sent previously...Since Provider did not fully comply with Rules 133.304 and 133.307, this request is premature and should be dismissed until Provider fully complies with the rules..."

Summary of Carrier's Position: Self-Insured reviewed the healthcare services and determined that reimbursement is not appropriate because additional information is needed to review the charges, the services provided were not substantiated, there was a separate evaluation and management service by the same physician, and the bills are subject to a reduction by the medical fee guideline..."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
9/9/04	F	97750-FC Functional Capacity Testing	1.	\$548.80
9/20/04	F	99213-office visit, 97032-elec. stim., 97124-massage, 97113-aquatic therapy	2.	\$327.82
TOTAL DUE				\$876.62

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

(MDR = Medical Dispute Resolution DOS = Date(s) of Service)

- Clarification of dispute submitted to MDR on 1/27/05.
 - a) The Respondent stated that they did not receive the first set of medical billing from the Requestor.
 - b) The Requestor submitted FedEx Tracking Detailed Results that was clearly picked up by FedEx on 9/24/04 and delivered by FedEx on 9/27/04 at 2:13 PM to Texas Municipal League, 2004 W. Jefferson #C, Harlingen, TX 78550.
 - c) The DOS submitted were 9/9/04 and 9/20/04. The CMS-1500's were dated 9/21/04 and 9/22/04, mailed on 9/24/04.
 - d) Date November 11, 2004 would be the approximate '45-days' after submission of the billing that the Respondent should have submitted a response with the first EOB.
 - e) The Requestor submitted CMS-1500's, marked "Request for Reconsideration" per the Respondent, on December 13, 2004. This would be the approximate timing after awaiting the '45-day' timeframe.
 - f) The Respondent did not clarify if they researched to see what happened to the FedEx receipt of a delivered "standard envelope" on 9/27/04 to carrier.
 - g) Therefore, MDR is accepting this request by the Requestor as a 'complete request' for Dispute Resolution.
- 1. DOS: 9/9/04 – CPT code 97750-FC x 16 units, the carrier paid \$00.00: The disputed issue is lack of reimbursement according to the denials: "F-Fee Guideline MAR Reduction; 105- Additional information needed to review charges, 130- Services unsubstantiated by documentation."

The Requestor documented four hours of time for competing the FCE and testing results. According to 134.202 (e)(4) and (c)(1), reimbursement shall be for up to a maximum of four hours for the initial test with the documentation.

Therefore reimbursement is recommended in the amount of (\$34.30 per unit x 16 =) **\$548.80**.

- 2. DOS: 9/20/04 - all CPT codes, the carrier paid \$00.00: The disputed issue is lack of reimbursement according to the denials: "F-Fee Guideline MAR Reduction; 105- Additional information needed to review charges, 130- Services unsubstantiated by documentation, 25- Separate E&M Service, same physician."

The Requestor documented services as billed with appropriate SOAP notes. Reimbursement recommended according to MAR (x 125%):

CPT code	MAR	Amount Due
99213	(\$49.58 x 125% =)	\$61.98
97032	(\$14.98 x 125% =)	\$18.73
97124 x 2	(\$21.02 x 125% = \$26.28 x 2 =)	\$52.56
97113 x 5	(\$31.13 x 125% = \$38.91 x 5 =)	<u>\$194.55</u>
		\$327.82

- Therefore, it is the conclusion of MDR that reimbursement in the amount of (\$548.80 + \$327.82=) \$876.62 is due.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. § 413.011(a-d)
28 Texas Administrative Code Sec. § 134.202 (e)(4) and (c)(1), MAR

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 \$876.62.**

Ordered by:

4 / 7 / 06

Authorized Signature

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.