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 Rd. Brownsvilee, TX 78521	MDR Tracking No.: M4-05-5031-01 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.: T120400095130

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Requestor's position statement- The carrier did not present any documentation to substantiate its reason for denying payment for services other than to say that the fees billed by South Coast Spine and Rehabilitation, P.A. exceeded the TWCC Medical Fee Guidelines.
2. Form 60
3. EOB's
4. CMS 1500 Forms

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Position statement: "The carrier maintains that all fee reductions were made in accordance with the applicable fee guidelines."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11/01/04	F	97546-WH	1	$25.60
TOTAL DUE				$25.60

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.

Please note, the requestor submitted a withdrawal on March 28, 2005 only for date of service 11/3/04, therefore, it will not be addressed.

1. The requestor billed 6 units for CPT code 97546-WH. The CMS 1500 form shows 6 units to have been billed and the EOB shows six units billed as well. Per Rule 134.202 (e) (5) (C) (ii) reimbursement shall be $64.00. per hour. The requestor is not CARF accredited, therefore, per Rule 134.202 (e) (5) (A) (ii), if the program is not CARF accredited reimbursement shall be 80% of the MAR. $64 (MAR) x 6 units= $384. 80% (non-carf rate) x $384 = $307.20. $307.20 (amount billed) - $281.60 previously paid = $25.60 owed.

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 $25.60.**

Ordered by:

Authorized Signature	Benita Diaz 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.