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 & Rehab 620 Paredes Line Rd. Brownsville TX 79521	MDR Tracking No.: M4-05-5063-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Brownsville ISD c/o Dean G. Pappas & Assoc. Rep Box #: 29	Date of Injury: Employer's Name: Brownsville ISD Insurance Carrier's No.: 04122078

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. TWCC-60
2. EOB's and HCFA's
3. SOAP notes / Documentation for services rendered

Position Summary: "…We are asking "the Division" to evaluate this request…to verify our request was made in the form, format and manner prescribed by the Commission…This dispute is a medical fee dispute…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

Position Summary: The Respondent did not submit a specific response, they did mark the 'Table of Disputed Services' with "F" acknowledging this is a fee dispute.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
10/21/04, 10/27/04	F	97035-ultrasound therapy x 2 days	A	$29.62
10/28/04, 11/1/04, 11/3/04, 11/4/04		97032-electric stim. therapy x 4 days	B	$74.92
10/28/04, 11/1/04, 11/3/04, 11/4/04		97124 x 2 units-massage therapy x 4 days	C	$210.24
10/28/04, 11/1/04, 11/3/04, 11/4/04		97113 x 5 units-aquatic therapy x 4 days	D	$311.28
TOTAL DUE				$626.06

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, EOB=Explanation of Benefits)

This dispute is related to lack of reimbursement for therapy treatment/services provided from 10/21/04 thru 11/4/04, beginning two days post automobile accident injury.

- A) CPT code 97035 for DOS 10/21/04 and 10/27/04: Denial reason code –"F –Fee guideline MAR reduction." The Requestor billed $14.81 a unit for a total of 2 days of ultrasound therapy. The Respondent responded with a payment of $00.00. Per Rule 134.202(b) the Respondent did not properly reimburse the Requestor. According to the Medical Fee Guideline /MAR for this CPT code is ($11.85 x 125%=) $14.81 per unit. The Requestor billed 2 DOS, therefore, reimbursement in the amount $14.81 x 2 days = **$29.62** is due.

- B) CPT code 97032 for DOS 10/28/04,11/1/04, 11/3/04 and 11/4/04: Denial reason code –"F –Fee guideline MAR reduction." The Requestor billed $18.73 a unit for a total of 4 days of electric stimulation therapy. The Respondent responded with a payment of $00.00. Per Rule 134.202(b) the Respondent did not properly reimburse the Requestor. According to the Medical Fee Guideline /MAR for this CPT code is ($14.98 x 125%=) $18.73 per unit. The Requestor billed 2 DOS, therefore, reimbursement in the amount $18.73 x 4 days = **$74.92** is due.

- C) CPT code 97124 for DOS 10/28/04,11/1/04, 11/3/04 and 11/4/04: Denial reason code –"F –Fee guideline MAR reduction." The Requestor billed $26.28 x 2 units for a total of 4 days of massage therapy. The Respondent responded with a payment of $00.00. Per Rule 134.202(b) the Respondent did not properly reimburse the Requestor. According to the Medical Fee Guideline /MAR for this CPT code is ($21.02 x 125%=) $26.28 per unit x 2 units a day = $52.56. The Requestor billed 4 DOS, therefore, reimbursement in the amount $52.56 x 4 days = **$210.24** is due.

- D) CPT code 97113 for DOS 10/28/04,11/1/04, 11/3/04 and 11/4/04: Denial reason code –"F –Fee guideline MAR reduction." The Requestor billed $38.91 x 5 units for a total of 4 days of aquatic therapy. The Respondent responded with a payment of $116.73 per day. Per Rule 134.202(b) the Respondent did not properly reimburse the Requestor. According to the Medical Fee Guideline /MAR for this CPT code is ($31.13 x 125%=) $38.91 per unit x 5 units a day = $194.55 less $116.73 paid= $77.82 due per day. The Requestor billed 4 DOS, therefore, additional reimbursement in the amount $77.82 x 4 days = **$311.28** 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

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 $626.06.**

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.