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: Texas Imaging & Diagnostic Ctr. 3840 W. NW HWY, Suite 400 Dallas TX 75220	MDR Tracking No.: M4-05-6174-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Travelers Indemnity Co of Conn Rep Box #: 05	Date of Injury: Employer's Name: Clampitt Paper Co of Dallas Insurance Carrier's No.: 039CBAUE0365

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. TWCC-60
2. EOB's and HCFA's
3. Documentation to support services rendered.

Position Summary: "…The insurance carrier has failed to reimburse our office for these procedures (99499, 62290 and 62290-51). Please note that this HCFA was 1 of 3 HCFA's submitted at the same time, same date for the same DOS. The other 2 HCFA's were properly processed and reviewed and the 3rd HCFA continues to be left out of the review.
This claim was originally submitted in July 2003 then resubmitted via mail August 2003…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Respondent did not respond to MDR.

Position Summary: NA

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
7/1/03	unknown	99499 – Unlisted Eval / Mgmt Serv. 62290* – Injection discography, each level 62290*-51 Multi-procedure	1.	$00.00
TOTAL DUE				$00.00

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 (MFG) For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, set out reimbursement guidelines.

(MDR = Medical Dispute Resolution DOS = Date(s) of Service EOB- Explanation of Benefits)

1. This dispute is related to lack of reimbursement for three additional CPT codes billed on 7/1/03, in addition to what the EOB's acknowledged as received for review by the Respondent.

- For DOS 7/1/03, the Requestor stated they submitted three (3) HCFA's dated 7/2/03 to the Respondent

seeking reimbursement for services rendered.

- The first EOB received for review was dated 7/28/03, with denial codes of "D- These services have already been considered for reimbursement." The Respondent reimbursed $00.00. The *disputed CPT codes* were not marked on the EOB as being received for review.
- The second EOB was dated 8/1/03, with reimbursement made in the total amount of $1,731.60. The *disputed CPT codes* were not marked on the EOB as being received for review.
- On 8/10/03, the Requestor sent a letter to the Respondent referencing this DOS of 7/1/03 and the CPT codes that had not been addressed in the previous EOB's. The letter stated in part, "…we are resubmitting this claim for reconsideration and payment. WE WERE NOT REIMBURSED FOR THE PROCEDURES ON THE ABOVE DOS. THIS HCFA (TOTALS OF $725.98) SEEMS TO BE LEFT OUT OF YOUR REVIEW, PLEASE REVIEW AND PROCESS PER THE TWCC GUIDELINES. I have also included for your review a copy of the EOB, bill and report. This documentation supports my request for payment to be made…"
- The Requestor acknowledges in part,that "We (they) were not reimbursed for the procedures on the above DOS…" yet they had recently received a check for DOS 7/1/03 in the amount of $1,731.60. "This HCFA" references only one HCFA and the amount they referenced was the total of the 3rd HCFA for DOS 7/1/03.
- The 3rd page of HCFA's, for this DOS 7/1/03, included four CPT codes. None of these CPT codes were on the EOB's presented for review, therefore this would have been considered a first submission for reimbursement consideration.
- In finalization of review, the Requestor did not submit convincing evidence that they submitted their billing in accordance with Rule 133.304 (k) and (m), therefore reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.304

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 not** entitled to additional reimbursement**.**

Ordered by:

		5 / 18 / 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.