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:	MDR Tracking No.: M4-05-A474-01
Gabriel R. Gutierrez, D.C. PO Box 229 Katy TX 77492-0229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Houston ISD Rep Box #: 42	Employer's Name: Houston ISD
	Insurance Carrier's No.: 02611 00000 47450001

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:
1. TWCC-60
2. EOB's and CMS-1500
3. Documentation to support the Requestors request for MDR

Position Summary: "…It is our position that the adjustor's and carrier's denial of payment is unreasonable, unjustified and is not in compliance…a) Payment for reasonable and necessary treatment/services provided…per the Texas labor Code Section 408.021 (a); b) Doctor…is a Level II Temporary Exemption Cert. Provider. It is the carrier's responsibility to check the TWCC Tex comp web site. C) MAR is not $00.00."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:
1. Respondent's response to MDR.
2. Copy of IME report dated 7/20/04.

A specific Position Summary was not included with the response.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
9/1/04 – 11/10/04	R F	99211-office visit x 13 days	A. 1.	$351.52
9/8/04		99212- office visit x 1 day	A. 2.	$48.03
9/1/04 – 10/20/04		97032 –elect.stim x 9 days	A. 3.	$180.27
9/1/04 – 11/10/04		97110 (4 units) therap.proc. x 16 days 97110 (3 units) therap. proc.1 day	A. 4.	$2,370.56 $111.12
9/1/04 – 10/20/04		97124- phy.massage x 8 days	A. 5.	$224.64
9/27/04		97140- manual therapy x 1 day	A. 6.	$33.91
10/27/04		99080 – 73 req.report	A. 7.	$15.00
9/27/04		99455 – VR, IR review	A. 8.	$50.00
TOTAL DUE				$3,385.05

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

A. 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 treatment/services rendered from 9/1/04 through 11/10/04.

- The Respondent's reconsideration EOB's were denied with the following codes:
  "Z3F" and "ZFK": Denial codes not recognized by MDR.
  "R / F": R- Extent of Injury, F – Fee guideline MAR reduction." The Respondent does not have a PLN on file, therefore this is an invalid denial. Reimbursement was $00.00. MAR is not $00.00, therefore stating paid per MAR reduction was also invalid.
  Due to the invalid denials submitted by the Respondent, the disputed DOS will be reviewed and reimbursed MAR according to rule 134.202 (c).

- Per the *Table of Disputed Services*, the DOS / CPT codes in dispute and recommended reimbursement per Rule 134.202 (c) is as follows:

  1. CPT 99211, 13 days (9/1/04 – 11/10/04) ($27.04 x 13 =) **$ 351.52**

  2. CPT 99212, 1 day (9/8/04) ($48.03 x 1 =) **$ 48.03**

  3. CPT 97032, 9 days (9/1/04 – 10/20/04) ($20.03 x 9 =) **$ 180.27**

  4. CPT 97110 (x 4 units ea.) ($37.04 x 4 = $148.16)
  16 days (9/1/04 – 11/10/04) ($148.16 x 16 =) **$2370.56**
  1 day (10/1/04) ($37.04 x 3 units=) **$ 111.12**

  5. CPT 97124, 8 days (9/1/04 – 10/20/04) ($28.09 x 8 =) **$ 224.64**
  (Per the CMS-1500, DOS 10/1/04 did not bill this code as noted on the *Table of Disputed Services*, therefore will not be considered further in this Finding and Decision.)

  6. CPT 97140 1 day (9/27/04) ($33.91 x 1 =) **$ 33.91**

  7. CPT 99080 – 73 (10/27/04) According to 133.306 (f)(1), required forms are reimbursed at **$15.00**.

  8. CPT 99455 -VR (9/27/04) According to 134.202 (e)(6)(F), the treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor. Using modifier "VR" indicates a review of the report only, and shall be reimbursed $50.00. Therefore accordingly, reimbursement of **$50.00** recommended.

  The total amount of reimbursement recommended is: $3,385.05.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.202, 133.306(f)(1), 134.202 (e)(6)(F)

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 $3,385.05** plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order**.**

Ordered by:

Authorized Signature	Typed Name	Date of Order
		6 / 7 / 06

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.