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 & Rehabilitation, P.A. 620 Paredes Line Rd. Brownsville TX 78521	MDR Tracking No.: M4-05-A930-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: US Specialty Ins. Co. Rep Box #: 49	Date of Injury: Employer's Name: Boggs & Tatum, Inc. Insurance Carrier's No.: 001922000304WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. TWCC-60
2. EOB's and HCFA's
3. Documentation for services rendered
4. Documentation to support the Requestors request for MDR

Position Summary: "We are…notifying the MDR…(we) were unable to agree on issues…We have complied with the above rule and we are entitled to submit a medical fee dispute…and not a medical necessity dispute…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

Position Summary not received.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
3/29/05	F/ unknown	99213 – office visit	A)	$00.00
3/30/05	F	99213 – office visit (paid) 97113 – aqua therapy x 4 units (paid) 97124 – therapeutic exercise x 2 units (paid)	B)	$00.00
3/31/05	F/ unknown	99213 – office visit 97113 – aqua therapy x 4 units 97124 – therapeutic exercise x 2 units	C)	$00.00
4/4/05	F / A	99213 – office visit (paid) 97113 – aqua therapy x 4 units 97124 – therapeutic exercise x 2 units	D)	$205.46
TOTAL DUE				$205.46

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 full reimbursement for office visits and therapy/treatment/services provided from 3/29/05 thru 4/4/05.
- Two EOB's were received by the Requestor out of the four DOS in dispute. Documentation substantiates submission to the Respondent according to 133.304 (K) and (M) timely, therefore the file will be reviewed for fee issues.
- The office visit S.O.A.P. report for DOS 4/4/05 was the only documentation received in file to review for services rendered. The report included references to DOS 3/30/05 and 3/31/05, but documentation for those DOS were not received for review.
- A) DOS 3/29/05: Requestor did not support this service with documentation to substantiate the service billed according to133.307 (g)(1)(B), therefore reimbursement not recommended.
- B) DOS 3/30/05: The EOB dated 8/2/05, shows reimbursement was made according to MAR therefore no additional reimbursement recommended.
- C) DOS 3/31/05: Requestor did not support these services with documentation to substantiate the services billed according 134.202, therefore reimbursement not recommended.
- D) DOS 4/4/05: The EOB received for this DOS showed the office visit was reimbursed according to MAR, therefore the remaining therapy will be reviewed. CPT codes 97124 x 2 units and 97113 x 4 units were denied with "A- Pre-certification for treatment should have been obtained by the provider prior to rendering services." This was an invalid denial according to 134.600 (h), therefore reviewing these two codes as fee issues. The SOAP notes provided substantiate the services billed according to 134.202. According to the Medical Fee Guideline / MAR reimbursement: for CPT 97124 x 2 units ($21.30 x 125%= $26.63 x 2 units) = **$53.26**, for CPT 97113 x 4 units ($30.44 x 125%= $38.05 x 4 units) = **$152.20.** Therefore reimbursement is recommended for this DOS in the amount of ($53.26 +$152.20=) **$205.46**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.600
28 Texas Administrative Code Sec. §133.304
28 Texas Administrative Code Sec. §133.307
Medical Fee Guideline 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 $205.46.**

Ordered by:

		4 / 13 / 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.