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-B818-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Brownsville ISD Rep Box #:	Date of Injury: Employer's Name: Brownsville ISD Insurance Carrier's No.: 05129143

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. TWCC-60
2. EOB's and CMS-1500's
3. Documentation for services rendered

Position Summary: "We are officially notifying MDR…(we) were unable to agree on issues…fee dispute…"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

Position Summary: A summary was not received 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
5/18/05	F	97110 x 5 units 97124 x 3 units	A)	$144.31
5/23/05, 5/25/05, 5/26/05	F	97124 x 3 DOS x $1.05 x 3	B)	$3.15
TOTAL DUE				$147.46

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)

1. This dispute was submitted to MDR for lack of reimbursement for office visits/therapy/ treatment/ services provided from 5/3/05 thru 5/26/05.
2. The Requestor submitted an updated 'Table of Disputed Services' showing they received reimbursement for most all of the DOS except for a few, therefore this review will be over only the following:

- A) DOS: 5/18/05 - CPT code 97110, the Requestor billed 5 units in the amount of $167.80. The Respondent reimbursed $103.38. The Respondent did not declare how many units they were reimbursing, as the amount for 3 units would have been ($26.85 x 125%=1 unit =)$33.56 x 3 =$100.68. The denial on the EOB was "W1 – Workers' Compensation State Fee Schedule Adjustment." The EOB for the reconsideration grouped DOS 4/25/05 – 5/25/05 together without putting DOS beside the CPT codes, therefore reconsideration reasons were unclear/undeterminable.

  The SOAP notes for this DOS documents 5 units of therapeutic exercises (97110) therefore reimbursement is recommended. Additional reimbursement is due: (Total due is $33.56 x 5 units = $167.80 less the paid amount of $103.38 =) **$64.42**.

  DOS: 5/18/05 – CPT code 97124, the Requestor billed 3 units in the amount of $79.89. The Respondent reimbursed $00.00. Denial code used on the EOBs was: "W1 – Workers' Compensation State Fee Schedule Adjustment." The EOB for the reconsideration grouped DOS 4/25/05 – 5/25/05 together without putting DOS beside the CPT codes, therefore reconsideration reasons were unclear/undeterminable.
  Review of the therapy units billed on this DOS reveals a total of eight (8) units utilized. According to other DOS before and after this DOS, the Respondent reimbursed eight units. According to 134.202 (e)(1), usual and customary charges were billed and reimbursed. The SOAP notes for this DOS documents 3 units of massage therapy (97124). Therefore additional reimbursement is due: (Total due is $21.30 x 125%= $26.63 x 3 units =) **$79.89**. Total due for DOS 5/18/05 = ($64.42 + $79.89=) **$144.31**.

- B) DOS: 5/23/05, 5/25/05 and 5/26/05 – CPT code 97124 was reimbursed in the amount of $78.84 on each DOS. The denial code used was "W1 – Workers' Compensation State Fee Schedule Adjustment."

  The Respondent did not explain how they arrived at their reimbursement of $78.84. According to 134.202(c)(1) reimbursement is 125% of Medicare (CMS). Therefore, additional reimbursement is due: ($21.30 x 125%= $26.63 x 3 units = $79.89 less paid amount of $78.84 = **$1.05 x 3 DOS= $3.15.**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.202
Medicare CMS

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 $147.46.**

Ordered by:

		4 / 19 / 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.