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 Name and Address: Hector J. Ortiz, M.D. 5409 Bellaire Blvd. Bellaire, TX 77401	MDR Tracking No.:	M4-07-3549-01 Current M4-06-6126-01 Prior
	Claim No.:	
	Injured Employee's Name:	
Respondent Name: ACE American Insurance Company Box 15	Date of Injury:	
	Employer's Name:	Steak & Ale Club
	Insurance Carrier's No.:	C290C610510X

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per Requestors Table of Disputed Services, "Injured employee was seen for reported areas of injury. Office visits medically necessary…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "An extent of Injury (compensability) issue was raised via a TWCC-21…"

Principle Documentation:

1. DWC 60 Response
2. CMS 1500s

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
05/24/05 – 06/23/05	W12 & W4	99213 X 2 DOS	1,2	$134.40
05/24/05 – 10/27/05	W12 & W4	99080-73 X 4 DOS	1,3	$60.00
08/25/05 – 10/27/05	W12 & W4	99214 X 2 DOS	1,4	$210.90
09/27/05	W9, W9	99080-73	1, 5	$15.00
TOTAL				**$420.30**

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

On February 12, 2007 the Requestor submitted a withdrawal for CPT code 99205 for date of service 09/27/05, therefore this issue will not be addressed in this Decision.

1. 1. According to the Respondent, the workers' compensation injury is to the low back. Review of the submitted CMS 1500's reveals that the Requestor billed using diagnosis codes 724.9 (Other unspecified back disorder), 724.4 (Thoracic/Lumbosacral Neuritis/Radiculitis Un), and 723.8 (Other Syndromes affecting cervical region). These diagnoses codes are related to the compensable injury. This review will be in accordance with Rule 134.202(b).

2. CPT code 99213 billed for date of service 05/24/05 & 06/23/05 was denied by carrier with denial codes "W12" (Extent of Injury. Not finally adjudicated), and "W4" (No additional reimbursement allowed after review of appeal/reconsideration). Per Rule 134.202 (c) (1), reimbursement is recommended in the amount of **$134.40 ($53.76 X 125% = $67.16 X 2 DOS = $134.32).**

3. CPT code 99080-73 code billed for dates of service 05/24/05, 06/23/05, 08/25/05 and 10/27/05 was denied by carrier with denial code "W4" (Disallowed; services do not appear related to work injury/diagnosis) and "W12 (Extent of injury. Not finally adjudicated). Per Rule 129.5 the DWC-73 is a required report and is not subject to an IRO review. The Medical Dispute Resolution has jurisdiction in this matter. Per Rule 129.5 (i) reimbursement is recommended in the amount of **$15.00 ($15.00 x 4 (DOS) = $60.00).**

4. CPT code 99214 billed for dates of service 08/25/05 & 10/27/06 was denied by carrier with denial codes "W12" (Extent of Injury. Not finally adjudicated), and "W4" (No additional reimbursement allowed after review of appeal/reconsideration). Per Rule 134.202(c) (1), reimbursement is recommended in the amount of **$210.90 ($84.36 X 125% = $105.45 X 2 (DOS) = $210.90).**

5. CPT code 99080-73 billed for date of service 09/27/05 was denied by carrier with denial code W9 (Unnecessary medical treatment based on peer review). The Medical Dispute Resolution has jurisdiction in this matter. Per Rule 129.5 (i) reimbursement is recommended in the amount of **$15.00.**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION FINDINGS 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 reimbursement in the amount of **$420.30.** The Division hereby **ORDERS** the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Order by:

	Eileen V. Atkinson Dispute Officer	February 16, 2007
Authorized Signature	Typed Name	Date Findings and 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.