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: Southeast Health Services P.O. Box 453062 Garland, TX 75045	MDR Tracking No.: M4-07-0171-01 Claim No.: Injured Employee's Name:
Respondent's Name: Dallas ISD Rep. Box # 42	Date of Injury: Employer's Name: Dallas ISD Insurance Carrier's No.: 2005036302

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "Code 99211 was denied as "global", please see the attached documentation marked Exhibit #2 for clarification of this service."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits (EOBs)
4. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary

None submitted

Principle Documentation: 1. DWC 60 packet

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)
12-29-05 thru 1-11-06	97H, W4	99211 (6 dates)	1-5	$169.68
2-27-06 3-1-06	W9, W4	99211	6	Withdrawn
12-30-05	W1, W4F	97140-59 97035 99070	7	Withdrawn
1-12-06	97H, W4	99213	1-4, 8	$65.15
TOTAL DUE				$234.83

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.

1. This dispute relates to procedures/services that were billed under CPT codes 99211, 97140-59, 97035, 99070, and 99213 that were denied/reduced reimbursement by the insurance carrier based upon: "97H – Payment is included in the allowance for another service/procedure; W4 – No additional reimbursement allowed after review of appeal/reconsideration; W9 – Unnecessary medical treatment based on peer review; W1 – Workers Compensation State Fee Schedule Adjustment; and W4F – No additional reimbursement allowed after review of appeal/reconsideration."

2. Per Commissioner's Bulletin #B-0006-06, "The CY 2005 conversion factor of $37.8975 is to be used effective immediately when calculating MAR for services provided on or after January 1, 2006."

3. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 8-28-06.

4. Based on Division Rule 133.307(d)(1-2), the only dates of service eligible for review are those commencing on 12-29-05 and extending through 3-1-06.

5. Per Rule 134.202(b), CPT code 99211 is not global to any other service billed on the disputed dates of service; therefore, the insurance carrier inappropriately denied reimbursement utilizing EOB denial "97H." Therefore, reimbursement is recommended per MFG. Per CMS-1500, the zip code 75217 is located in Dallas County. The MFG MAR for CPT code 99211 in Dallas County is $28.28. This amount times 6 dates = $169.68.

6. On 12-11-06, the Requestor's representative, Jennifer Davidson, withdrew disputed dates of service 2-27-06 and 3-1-06 that contained medical necessity issues.

7. On 12-4-06, the Requestor's representative, Jennifer Davidson, withdrew disputed date of service 12-30-05 that contained medical necessity issues.

8. Per Rule 134.202(b), CPT code 99213 is not global to any other service billed on the disputed dates of service; therefore, the insurance carrier inappropriately denied reimbursement utilizing EOB denial "97H." Therefore, reimbursement is recommended per MFG. The MFG MAR for CPT code 99213 in Dallas County is $68.32 or less per Rule 134.202(d)(2). Per the Table of Disputed services, the Requestor is seeking medical dispute resolution for $65.15, this amount is recommended.

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 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 **$234.83.** The Division hereby **ORDERS** the insurance carrier 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.

Ordered by:

	Elizabeth Pickle, RHIA	January 8, 2007
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.