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: Nestor Martinez, DC 6660 Airline Dr. Houston, TX 77076	MDR Tracking No.: M4-07-0199-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Insurance Co. of the State of PA Rep. Box # 19	Date of Injury: Employer's Name: CNF Inc. Insurance Carrier's No.: 478CBAGH2659

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary listed on the Table of Disputed Services:

"The Carrier did not respond to the RFR."

Principle Documentation:

1. DWC-60
2. CMS-1500
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary:

"This dispute concerns DOS 8/30/2005, an impairment rating evaluation performed by a referral doctor. There is no documentation of the treating doctor requesting that this IR evaluation be performed, nor was this documentation attached to the original billing. In addition, it is the Carrier's position that the IR evaluation was not reasonable and necessary, nor was it adequately documented to be entitled to reimbursement."

Principle Documentation: 1. DWC-60

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)
8-30-05	T019	99455-WP-V3 - Evaluation for MMI/IR	1-5	$217.20
TOTAL DUE				$217.20

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, set out reimbursement guidelines.

1. This dispute relates to whether additional reimbursement is due for code 99455-V3-WP. The insurance carrier paid $0.00 of the $350.00 billed based upon, "T019 – Claim/Service lacks information needed for adjudication. Add/l info is supplied using remittance advice remarks codes where appropriate. The billed PX code requires a modifier. Please re-bill using correct modifier."

2. The Respondent did not comply with Rule 133.307(j)(2) by raising issues that were not presented to the Requestor prior to request for medical dispute resolution. This review will be limited to the EOB listed in #1 above.

3. According to Rule 134.202(e)(6)(C)(i)(I), "Reimbursement shall be the applicable established patient office visit level associated with the examination." The Requestor billed with modifier 'V3'; therefore, denial of T019 was inappropriate. Per Rule134.202(c)(1), the MAR for 99213 in Harris County is $67.20.

4. According to Rule 134.202(e)(6)(D)(II), "The MAR for musculoskeletal body areas shall be as follows.

a) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th Edition is used.

b) If full physical evaluation, with range of motion is performed:

1) $300 for the first musculoskeletal body area; and

2) $150 for each additional musculoskeletal body area.

5. The Requestor evaluated claimant's lumbar spine (DRE method), which results in recommended reimbursement of $150.00 per Rule 134.202(e)(6)(D)(II).

The Requestor is entitled to $150.00 + $67.20 = $217.20 for the disputed services.

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 $217.20 plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Decision and Order by:

	Elizabeth Pickle, RHIA	November 27, 2006
Authorized Signature	Typed Name	Date of Decision

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.