Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Jerrod M. Cashion, D.C. 1605 Rock Prairie Road Suite 222 College Station, TX 77845	MFDR Tracking #: M4-07-3757-01 CURRENT M4-07-3789-01 DISMISSED (DUP) DWC Claim #: Injured Employee:
Respondent Name and Box #: Travelers Indemnity Co. Box 05	Date of Injury: Employer Name: Mike Hopkins Distributing Inc. Insurance Carrier #: 478CBAAR0282

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Requestor did not submit a Position Summary to MFDR.

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a Position Summary to MFDR.

Principle Documentation:

1. Response to DWC 60
2. EOBs

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
08/26/06	W9, 50	99455-V3-WP	1	$361.62
Total Due:				$361.62

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

1. CPT code 99455-V3-WP billed for date of service 08/26/06 was denied by carrier with reason code "W9" (Unnecessary treatment per required medical exam) and "50" (These are non-covered services because this is not deemed a 'medical necessity' by the payer). Medical Fee Dispute Resolution has jurisdiction in this matter; this is not subject to an IRO review therefore, therefore the carrier denied this service inappropriately.

Per Rule 134.202 (e) (6) (c) (i), the requestor billed with modifier V3, therefore recommended reimbursement is $61.62.

- 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.

The Requestor documented a ROM method and billed for one body area per the CMS-1500. Therefore, reimbursement for this impairment rating is $300.00. This amount plus MMI evaluation equals $361.62. The insurance carrier paid $0.00; therefore, the Requestor is due $450.00.

A Legal & Compliance Referral has been made against the Respondent for violation of rule 134.202(d) (6) (C) (i) (II) and (D) (iii) (II) (b).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION DECISION AND/OR 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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$361.62** plus accrued interest, due within 30 days of receipt of this Order.

Decision:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Eileen V. Atkinson	04/13/07

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.