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

Requestor's Name and Address: Glenn J. Bricken, Psy.D. 25810 Oak Ridge Drive The Woodlands, Texas 77380	MDR Tracking #. M4-07-4341-01 Claim #: Injured Employee:
Respondent's Name and Box #: Texas Mutual Insurance Company Box #54	Date of Injury: Employer's Name: Minute Man of America, Inc. Insurance Carrier's #: 99A0000261352

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "Service is not global/bundled…" "Unbundling in [sic] not applicable in this situation as this report was an individual service that was not attached to any other procedure. This is further substantiated by the fact that the narrative in question is the only item billed for date of service June 23, 2006."

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary in part, "Texas Mutual denied code 99080 based on the bundled status assigned to this code, no reimbursement is due." "According to Rule 133.106(f)(2)(E); clinical or progress notes do not constitute a narrative report…the requestor billed his clinical/progress notes for the visit in narrative form in an effort to receive payment based on Rule 133.106. The report submitted was neither requested required this is not a 'required report (i.e. DWC-73), therefore Texas Mutual believes separate reimbursement is not due for clinical/progress notes provided by the requestor.

Principle Documentation: 1. DWC 60 package

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)
06/23/2006	97, 284	99080	1-4	$0.00
TOTAL DUE				$0.00

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 a procedures/services that was billed under CPT code 99080 for DOS 06/23/2006.

2. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 3/27/2007.

3. Based on Division Rule 133.307(d) (1-2), the only date of service eligible for review is 06/23/2006.

4. CPT code 99080 is defined as special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. The Respondent denied reimbursement based upon "97—Payment is included in the allowance for another service/procedure" and "284—No allowance was recommended as this procedure has a Medicare status of 'B' (bundled)." Upon request for reconsideration, reimbursement was again denied based upon "97—Payment is included in the allowance for another service/procedure" and "284—No allowance was recommended as this procedure has a Medicare status of 'B' (bundled)." Per Rule 134.202, narrative reports are not global and may be reimbursed. A review of the CMS-1500 indicates that the Requestor utilized modifier "N-5"; this modifier is not contained in Rule 134.202. A narrative report is defined in Rule 133.106(e) as "…original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed. Narrative reports shall provide information beyond that required by prescribed report forms. The narrative reports should be no more than double-spaced on letter size paper. Clinical or progress notes do not constitute a narrative report." The Requestor submitted the psychological progress report to support billing. The report of the psychological progress is global to that service. The Requestor did not submit a separate narrative report to support billing; therefore, no reimbursement is recommended.

Therefore it is the conclusion of the Medical Dispute Resolution that reimbursement is not due the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §134.1 and §134.202

PART VII: DIVISION DECISION

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 not entitled to reimbursement.

Decision by:

		05/22/2007
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.