MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor's Name and Address **SCD Back and Joint Clinic, Ltd.** **200 E. 24th Street, Suite B** **Bryan, Texas 77803**	MDR Tracking No.: M5-05-2252 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **TX Mutual Insurance Company, Box 54**	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-19-04	4-21-04	CPT codes 99070 and 97124	$145.71	0

PART III: REQUESTOR'S POSITION SUMMARY

The requestor withdrew CPT codes 98943 and 97012 in a letter dated 5-9-05. These will not be a part of this review.

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent denied CPT code 99070 on 4-19-04 (2 services) as "F – The code billed is invalid." Per Medicare Fee Guidelines this is not a valid code for these services. **Recommend no reimbursement.**

The carrier denied CPT code 97124 on 4-19-04 and 4-21-04 as "Z3-this procedure is considered integral to the completion of the comprehensive procedure." Per Medicare Fee Guidelines CPT code 97124 is considered to be a component of CPT code 98940 which was billed on this date of service. **Recommend no reimbursement.**

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

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one (1) year after the date(s) of service in dispute. The following date of service is not timely and is not eligible for this review: 4-16-04.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to reimbursement.

Findings and Decision by:

Authorized Signature	Typed Name	7-7-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____