



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Texas Health 5445 La Sierra Dr. #204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1831-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Dallas National Insurance Company, Box 20	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary, "... It is our position that AMS Staffing Leasing has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to the injured worker...."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "... With regard to sole point of contention, Respondent maintains that it complied with the Texas Labor Code and the rules promulgated by the Division of Workers' Compensation. Thus, Respondent maintains that it should not be responsible to reimburse Requestor any unnecessary fees...."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. EOB's
3. Peer Review

### 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)
6-24-05	39, 97	90806	1	\$0.00
6-29-05, 7-07-05, 7-15-05	W9, W4	90806	2	\$0.00
Total Due				\$0.00

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

CPT code 90880 from 6-24-05 – 7-15-05 was withdrawn by the Requestor and will not be a part of this review.

1. The Respondent denied these services as “39(880-106) – Services denied at the time authorization/pre-certification was requested” and “97(509) – Payment is included in the allowance for another service.” Per Rule 134.202 this procedure is considered by Medicare to be a component procedure of CPT code 90880 which was billed on this date of service. The services represented by the code combination will not be paid separately. Recommend no reimbursement.
2. The Respondent denied these services as “W-9-Unnecessary medical treatment based on a peer review” and “W-4-No additional reimbursement allowed.” Per Rule 134.202 this procedure is considered by Medicare to be a component procedure of CPT code 90880 which was billed on this date of service. The services represented by the code combination will not be paid separately. Recommend no reimbursement.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. §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 not entitled to reimbursement for the services involved in this dispute.

Ordered by:

Medical Dispute Officer

8-10-06

\_\_\_\_\_  
 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.**