



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: Health Care Provider Injured Employee Insurance Carrier

Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1850-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary, "Services were medically necessary - this is a one-one procedure to improve functional performance... Services were medically necessary - increases ROM, flexibility and muscle strength; helps prevent future recurrences."

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

Position Statement submitted by Texas Mutual did not address the disputed services.

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)
7-22-05, 8-19-05	W4, B15, 891, 434	97530	1	\$0.00
Total Due			1	\$0.00

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

In a letter dated 8-8-06 the Requestor withdrew the services which were denied for medical necessity.

1. The Respondent denied these services as “W4-No additional reimbursement allowed,” “B-15-Payment adjusted because this procedure is not paid separately,” “891-The insurance company is reducing or denying payment after reconsideration,” and “434-Per CCI Edits, the value of this procedure is included in the value of the mutually exclusive procedure.” CPT code 97530 is considered by Medicare to be a “mutually exclusive procedure of CPT code 97140-59 which was billed on this date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The services represented by the code combination will not be paid separately.” The Requestor did not bill with an appropriate modifier for CPT code 97530. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor 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.

Decision by:

Medical Dispute Resolution

8-10-06

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.