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

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Southeast Health Services P. O. Box 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-1909-01 Previous MDR Tracking No.: M4-06-4476-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Regarding the Requestor's Position Summary: The Requestor has attached exhibits regarding each service in dispute.

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 states, "The medical records do not indicate additional time was spent explaining results of tests or any type of treatment plan."

Principle Documentation:

4. DWC-60/Table of Disputed Service
5. CMS-1500's
6. EOB's

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)
3-7-05	97H	99354-25	1	$127.49
3-18-05	97H	99214-25	2	$107.01
3-21-05	W1A	97110	3	$72.00
4-1-05	D19	97140-59	4	$34.16
TOTAL DUE				$340.66

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, set out reimbursement guidelines.

In a letter dated 7-20-06 the Requestor withdrew dates of service denied for medical necessity. Therefore, this dispute contains fee issues only. The Respondent did not submit reconsideration EOB's as requested by the Requestor on 9-23-05. Therefore, review will be based upon initial denial codes.

1. The Respondent denied this service as "97H-Payment is included in the allowance for another service/procedure." Per the 2002 MFG, this service is not global to any other service performed on this date. Recommend reimbursement of $127.49.
2. The Respondent denied this service as "97H-Payment is included in the allowance for another service/procedure." Per the 2002 MFG, CPT code 99214 is a "component procedure of CPT code 98941 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 Requestor did use the modifier "25" appropriately. Recommend reimbursement of $107.01.
3. The Respondent denied this service as "W1A-Workers Compensation State Fee Schedule Adjustment." SOAP notes substantiate the service rendered. Per the 2002 MFG recommend reimbursement of one unit @ $36.14.
4. The Respondent denied this service as "D19-Claim/Service lacks Physician/Operative or other supporting documentation." The office notes submitted for date of service 4-1-05 does meet the documentation criteria set forth by the CPT Code descriptor for CPT Code 97140-59. Reimbursement of $34.16 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code §413.011(a-d) and 413.031
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** entitled to reimbursement in the amount of $340.66. The Division hereby **ORDERS** the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

	Medical Dispute Resolution	8-11-06
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.