



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: Health Care Provider Injured Employee Insurance Carrier

Requestor's Name and Address:

Southeast Health Services
P. O. Box 453062
Garland, Texas 75045

MDR Tracking No.: M5-07-0590-01

Previous Tracking No.: M4-05-B350-01

Claim No.:

Injured Employee's Name:

Respondent's Name:

LIBERTY INSURANCE CORP., Box 28

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary (Table of Disputed Services) states in part, "Please see the attached documentation marked Exhibit 1 for clarification of code 97140-59."

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary (Table of Disputed Services) states in part, "Mutually Exclusive to 98940 or 98941."

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)
8-12-04 – 8-20-04	G	97140-59 (\$34.13 x 4 units)	1, 2, 3, 4	\$136.52
TOTAL DUE				\$136.52

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

Section §413.011(a-d) titled, Reimbursement Policies and Guidelines, and Division Rule 134.202 titled, Medical Fee Guideline effective August 1, 2003, sets out the reimbursement guidelines.

- 1) In a letter dated 1-30-07 the Requestor withdrew CPT code 99354-25 billed on 8-12-04 that was denied for medical necessity. In an e-mail dated 3-28-07 the Requestor withdrew date of service 8-30-04. These services will not be a part of this review.

- 2) The carrier denied these services as “G-This is a bundled procedure; no separate payment allowed.”
- 3) Per Rule 134.202(b) this procedure is considered to be a component procedure of CPT code 98940 and 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 billed with a modifier.
- 4) Per the CMS 1500 Zip Code 75217 is in Dallas County. The MAR for 97140 in Dallas County is \$34.13. This amount is recommended for reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 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 additional reimbursement in the amount of \$136.52. The Division hereby **ORDERS** the insurance carrier 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:

4-19-07

 Authorized Signature

 Typed Name

 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.