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

Requestor's Name and Address: Alpine Healthcare Clinic, L.P. 1621 N. Main Avenue Suite 5 San Antonio, TX 78211	MDR Tracking No.: M4-05-0214-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Builders Insurance Company Rep Box # 01	Date of Injury: Employer's Name: Sterling Sleep Products Inc. Insurance Carrier's No.: 8864C

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent states they submitted a request for reconsideration on 07/16/04. Proof that the carrier received the request is also included in the dispute. Carrier chose not to respond to the request for reconsideration. TWCC Rule 133.307(j)(20 states that only the reason bought up by the carrier can be heard at MDR.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Carrier did not submit a position summary.

Principle Documentation: 1. N/A

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)
01/02/04	F	95851	1	$00.00
01/02/04	G	96004	2	$143.79
01/02/04	Y	97035	3	$14.81
01/02/04	Y	97110	4	$34.46
01/02/04	Y	97140	5	$00.00
11/24/03	F	97116	6	$00.00
11/19/03	F	97124	7	$00.00
11/19/03	F	97750	8	$00.00
TOTAL DUE				$193.06

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003 set out reimbursement guidelines.

1. CPT Code 95851 for Date Of Service 01/02/04 has been paid in accordance with Medicare fee schedule plus 125%. No further reimbursement is recommended per Rule 134.202(b).

2. CPT Code 96004 for Date Of Service 01/02/04. Per rule 134.202(b) and CMS Correct Coding Initiative (CCI) , This is not considered global to any code billed on this date of service. Therefore reimbursement in the amount of $143.79 ($115.03 x 125%) is recommended.
3. CPT Code 97035 for Date Of Service 01/02/04, Carrier denied services as "F-Payment Policy" but made no payment. Per Rule 134.202(b) reimbursement in the amount of $14.81 ($11.85 x 125%) is recommended.
4. CPT Code 97110 for Date Of Service 01/02/04 was denied as "F-Payment Policy" with no reimbursement made by the carrier. Per rule 134.202(b) reimbursement in the amount of $34.46 ($27.57 x 125%) is recommended.
5. CPT Code 97140 for date Of Service 01/02/04 denied as "Y-Payment Policy". Per Rule 134.202(b) and CMS CCI edits this code is a component of CPT code 95831 billed on the same day. A modifier is allowed to substantiate payment but the requestor did not apply a modifier, therefore reimbursement is not recommended.
6. CPT Code 97116 for Date Of Service 11/24/03 denied as "F-Payment Policy & R89-CCI Edit" per Rule 134.202(b) & CMS – CCI edits this code is a component of CPT Code 96004 that was billed on the same date of service; a modifier is allowed, however the requestor did not attach a modifier, therefore no reimbursement is recommended.
7. CPT Code 97124 for Date Of Service 11/19/03 denied as "F-Payment Policy & R79-CCI Edit" per Rule 134.202(b) & CMS – CCI edits this code is a component of CPT Code 97140 that was billed on the same date of service; a modifier is allowed, however the requestor did not attach a modifier, therefore no reimbursement is recommended.
8. CPT Code 97750 for Date Of Service 11/19/03 denied as "F-Payment Policy & R84-CCI Edit" per Rule 134.202(b) & CMS – CCI edits this code is a component of CPT Code 97140 that was billed on the same date of service; a modifier is allowed, however the requestor did not attach a modifier, therefore no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
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 $193.06.**

Ordered by:

		01/13/06
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.