MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Valley Anesthesia Consultants P.O. Box 720550 Mcallen, TX 78504	MDR Tracking No.: M4-05-1617-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 Texas Mutual Insurance Company	Date of Injury: Employer's Name: Christian Family Services Management Corp. Insurance Carrier's No.: 99D-345193

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/21/04	**04/21/04**	**64415-59**	**$600.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement consists of the medical records (anesthesia intra-operative record & anesthesia medical history) for the services rendered on the above date of service in dispute.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent states in part "This carrier denied the charge (64415-59) in dispute with explanation code "G" and the explanation, THE PAYMENT FOR THIS SERVICE IS ALWAYS BUNDLED INTO PAYMENT FOR OTHER SERVICES. MEDICARE CCI EDITS APPLY." Medicare does not provide reimbursement for code 64415 and 01622 per National Correct Coding Edit (CCI). (Exhibit 2) It is the carrier's position that the block was an adjunct to the anesthetic, therefore reimbursement for the block was provided in the reimbursement for the services billed with code 01622. Review of the operative report and anesthesia record does not support that the anesthesiologist was responsible for pain management after the time in the operating room. (Exhibit 2) The documentation supports that the nerve block was NOT "distinct or independent" as it was performed during the time frame for which the requestor also billed MAC.

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

Per Medicare CCI edits, 64415 is included in the reimbursement for the anesthesia service 01622. Modifier 59 may be used to identify a "distinct procedural service", however, the requestor did not provide documentation to substantiate the use of this modifier as a "distinct procedural service".

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
4/21/2004	64415-59	$600.00	$0.00				
				Total Left Column:			$600.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Authorized Signature	Benita Diaz Typed Name	May 20, 2005 Date

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____