



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestors Name and Address: Eric A. VanderWerff, D.C. 615 N. O'Connor Road, Suite # 12 Irving, Texas 75061	MDR Tracking No.: M4-05-1991-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: Twin City Fire Insurance Company Rep Box # 27	Date of Injury:
	Employer's Name: Wind River Roofing Inc
	Insurance Carrier's No.: YBUC 38136

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Service is listed as a separate procedure in the fee guidelines and is not integral to any primary procedure billed."

- Principle Documentation:
1. DWC 60 package
 2. CMS 1500's
 3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part "Thus, it is the Carrier's position that Eric A. VanderWerff, D.C. has failed to submit a proper request for reconsideration and thus request the Medical Dispute Resolution Request be dismissed."

- Principle Documentation: 1. Response to 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)
01-26-04, 01-29-04, 02-04-04, 02-09-04, 02-12-04, 02-19-04, 03-01-04, 03-10-04, 03-15-04, 03-18-04, 03-24-04, 03-25-04 and 03-31-04	F	97140-59 (1 unit @ \$34.05 X 2 units X 13 DOS)	(1-4)	\$885.30
01-26-04, 01-29-04, 02-04-04, 02-09-04, 02-12-04, 02-19-04, 03-01-04, 03-10-04, 03-15-04, 03-18-04, 03-24-04 and 03-31-04	N	98941	(5-6)	\$0.00

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
01-28-04, 02-02-04, 02-05-04, 02-11-04, 02-18-04, 02-26-04, 03-03-04, 03-11-04, 03-17-04 and 03-23-04	NO EOB	97140-59 (1 unit @ \$34.05 X 2 units X 10 DOS)	(3,4,7,8,9)	\$681.00
01-28-04, 02-02-04, 02-05-04, 02-11-04, 02-18-04, 02-26-04, 03-03-04, 03-11-04, 03-17-04, 03-23-04 and 03-25-04	NO EOB	98941 (1 unit @ \$45.74 X 11 DOS)	(7,8 & 10)	\$503.14
TOTAL DUE				\$2,069.44

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, sets out reimbursement guidelines.

- (1) The Respondent denied the services with denial code “F” (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed).
- (2) CPT code 97140 billed on the dates of service in dispute is a component procedure of CPT code 98941 and a mutually exclusive procedure of CPT code 97012, both billed on the dates of service in dispute.
- (3) A modifier is allowed in which to differentiate the services provided and payment for the service is justifiable if an appropriate modifier is billed.
- (4) The Requestor billed with an appropriate modifier, therefore, reimbursement is recommended per Rule 134.202(d)(2) in the amount listed above.
- (5) The Respondent denied the services with denial code “N” (documentation does not justify level of service. Resubmit using code for appropriate lower level of service).
- (6) Documentation submitted for review by the Requestor does not support the services billed. No reimbursement is recommended.
- (7) Neither party submitted copies of EOB’s for the services in dispute.
- (8) Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence of the Respondent’s receipt for EOBs.
- (9) CPT code 97140 billed on the dates of service in dispute is a component procedure of CPT code 98941 also billed on the dates of service in dispute.
- (10) Reimbursement recommended per Rule 134.202(d)(2).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202(d)(2), 133.307(e)(2)(B) and 134.202

PART VII: DIVISION FINDINGS 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 \$2,069.44. 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.

Order by:

10-24-06

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.