Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	
Edward F. Wolski M.D. – Wol+ Med 2436 I-35 East, South, Suite 336 Denton, TX 76205	MFDR # M4-05-3031-01 DWC Claim # Injured Employee
Respondent Name and Box #: 54 TEXAS MUTUAL INSURANCE CO	Date of Injury Employer Name DSP ENTERPRISES Insurance Carrier # 99D0000346560

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier did not use the correct PEC. These particular CPT codes do not have a MAR. The carrier violated TWCC Rule 133.304 (c)."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "It is the carrier's position that the requestor did not code to the highest level of specificity. The requestor billed code 97799, unlisted physical medicine/ rehabilitation service or procedure, for a massage. Code 97124 is defined as "Therapeutic procedure, one or more areas, each 15 minutes. Massage, including effleurage, petrissaage and or tapotement (stroking, compression, percussion)." The service in dispute is a massage".

Principle Documentation:

1. Response to DWC 60
2. EOB

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
04/05/04, 04/06/04, & 04/13/04	JM, YO	97799-22	1,2	$00.00
Total Due:				

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

1. CPT code 97799-22 billed for dates of service 04/05/04 – 04/13/04 was denied by carrier with reason codes "JM – Accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is

invalid. Please refer to the applicable medical fee guideline and/or Medicare guideline for the correct code or modifier for the service rendered.” and “YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed”, and

2. Code 97799-22 is classified as 'unspecified', 'other', or 'ill-defined. Per Rule 134.202 (b), CPT code 97799-22 is not valid, therefore, reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION DECISION

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 not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	06/21/07 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.