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: Jacob Rosenstein, M.D. 800 W. Arbrook Blvd. # 150 Arlington, Texas 76015	MFDR Tracking #: M4-05-4031-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Insurance Company of the State of PA Rep Box # 19	Date of Injury: Employer Name: United Technologies Corporation Insurance Carrier #: 149122886

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "documented in operative report…"

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: "This dispute concerns date of service 5/7/04. Carrier maintains that it paid according to the applicable law, rules and fee guidelines."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
05-07-04	1/N/F	20936	1, 2, 7	$00.00
05-07-04	1/5/N/F	22899-51	1, 3, 7	Reimbursement per Rule 134.202(c)(6)
05-07-04	1/5/N/F	27299-51	1, 4, 7	Reimbursement per Rule 134.202(c)(6)
05-07-04	5/6/F	63047-51	1, 5, 7	$619.71
05-07-04	7/F	63048	1, 6, 7	$261.15
Total Due:				$874.66 plus reimbursement per Rule 134.202(c)(6)

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, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with denial reasons:

   (1) This is an unlisted procedure. Please resubmit with a more descriptive code.
   (5) The charge exceeds the scheduled allowance for multiple procedures.
   (6) By clinical practice standards, this procedure is incidental to the related primary procedure.
   (7) Procedure code should not be billed without appropriate primary procedure.
   (8) N - Not documented.
   (9) F - Fee Guideline MAR reduction.

2. In regard to CPT code 20936 per Rule 134.202(b) this is a valid code, however, in addition per Rule 134.202(b) CPT code 20936 is a bundled code; therefore, no reimbursement is recommended.

3. In regard to CPT code 22899-51 per Rule 134.202(b) this is a valid code. Reimbursement is recommended per Rule 134.202(c)(6).

4. In regard to CPT code 27299-51 per Rule 134.202(b) this is a valid code. Reimbursement is recommended per Rule 134.202(c)(6).

5. In regard to CPT code 63047 per Rule 134.202(b) CPT code 63047 is a component procedure of CPT code 22630 also billed for date of service 05-07-04. A modifier is allowed to differentiate between the services provided and separate payment is considered if an appropriate modifier is billed. The Requestor billed with modifier 51. Per Rule 134.202(b) standard payment adjustment rules for multiple procedures apply. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of $619.71 ($991.52 x 125% = $1,239.41 x 50%).

6. In regard to CPT code 63048 per Rule 134.202(b) this is an add-on code and must be billed in conjunction with CPT code 63045 – 63047. CPT code 63047 was also billed for date of service 05-07-04. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of $261.15.

7. Per review of Box 32 on CMS-1500 zip code 76017 is located in Tarrant County.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1 and §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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $874.66 plus reimbursement per Rule 134.202(c)(6 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		07-20-07
Authorized Signature	Medical Fee Dispute Resolution Officer	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.