Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Trinity Physical Medicine 2800 Brown Trail Bedford, TX 76021	MFDR Tracking #: M4-05-5460-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TRANSCONTINENTAL INSURANCE CO BOX 47	Date of Injury: Employer Name: ELECTRIC ONE INC Insurance Carrier #: 64806818

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Please see the attached letter of clarification for charges considered global."

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: "Carrier respectfully submits its TWCC-60 response with supporting documentation."

Principle Documentation:

1. Response to DWC 60
2. EOB(s)

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
3-18-04	G (509-001)/no recon	97530	1, 2	$0.00
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, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "G (509-001) – Unbundling – Correct coding initiative bundle guidelines indicate this code is a mutually exclusive code, considered included in another code on the same day."

2. According to Rule 134.202(b), CPT code 97530 is considered a "bundled code" and it is mutually exclusive to CPT code 97140 billed on the same date of service. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION DECISION AND/OR 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 not entitled to reimbursement for the services involved in this dispute.

Decision:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Donna D. Auby	4-16-07

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.