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

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.:	M4-05-6417-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: LM Insurance Corporation Rep Box # 28	Date of Injury:	
	Employer's Name:	C&D Commercial Masonry Inc.
	Insurance Carrier's No.:	949806852

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "You have incorrectly (unreasonably) denied/reduced these services which is a violation of the Texas Labor Code. Please remit payment immediately."

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: "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules."

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)
11-23-04 to 12-22-04	G/U687	97140-59 (1 unit @ $34.16 X 2 units X 17 DOS)	(1-3)	$1,161.44
TOTAL DUE				$1,161.44

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 services were denied by the Respondent with denial code "G/U687" (this procedure is mutually exclusive to another on this date of service. By clinical practice standards, this procedure should not or cannot be performed in the same treatment period).
(2) Per Rule 134.202 CPT code 97140 is mutually exclusive to CPT code 97012 and a component procedure of CPT code 98941 also billed on the dates of service in dispute. A modifier is allowed to differentiate the services provided and separate payment is considered justifiable if an appropriate modifier is used.
(3) The Requestor billed with an appropriate modifier (59), therefore, per Rule 134.202(c)(1) reimbursement is recommended in the amount listed above.

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(c)(1)

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 $1,161.44. 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:

		10-25-06
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.