



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Alta Healthcare Clinic, L.P. 2500 W. Freeway #200 Fort Worth, TX 76102	MDR Tracking No.: M4-05-6465-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Rep Box # 19	Date of Injury:
	Employer's Name: Gevity HR Inc.
	Insurance Carrier's No.: 149139969

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states that the services in dispute are not global to any other service.
 Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The respondent states they have paid according to the applicable fee guidelines.
 Principle Documentation: 1. TWCC-60 Response

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)
04/28/04	G	95833	1	\$00.00
04/28/04	G	95851	2	\$00.00
TOTAL DUE				\$00.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

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

1. CPT Code 95833 for date of service 04/28/04 denied with "F". Per Rule 134.202(b) and CMS –CCI Edits (Center For Medicare Services Correct Coding Initiative) this code is a component procedure to CPT Code 99213 which was billed on the same date of service and there are no circumstances in which a modifier would be appropriate, therefore reimbursement is not recommended.
2. CPT Code 95851 for date of service 04/28/04 denied with "F". Per Rule 134.202(b) and CMS –CCI Edits (Center For Medicare Services Correct Coding Initiative) this code is a component procedure to CPT Code 95833 which was billed on the same date of service and there are no circumstances in which a modifier would be appropriate, therefore reimbursement is not recommended

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §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 not** entitled to additional reimbursement.

Ordered by:

02/24/06

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.