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

Requestor=s Name and Address: Rehab First P O Box 453062 Garland, Texas 75045	MDR Tracking No.: M4-05-B834-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company Box 19	Date of Injury: Employer's Name: BGM Industries, Inc. Insurance Carrier's No.: 003960000706100

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary per the Table of Disputed Services: "This is a identifiable procedure. This was separate from the injections that were performed, I have added the –25 modifier to the office visit and attached documentation to support that this procedure is not global in this situation."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Summary Position
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Principle Documentation:

1. Summary Position
2. 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)
08/25/04	UCM (G) (U849)	CPT code 99214-25	1 and 2	$106.36
Total				$106.36

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. Respondent denied these services, as "UCM (G) -This office visit is included in the value of the surgery or anesthesia procedure (U454)."

2. CPT code 99214-25 for date of service 08/25/04, is not considered global to any other procedure for this date of service, because the requestor used the –25 modifier to indicate the office visit is separate from the injections per Rule 134.202. Therefore, reimbursement in the amount of $106.36 is recommended. ($85.09 x 125% = $106.36)

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Labor Code Sec.§ 413.031
28 Texas Administrative Code Sec. §134.1
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** entitled to reimbursement **in the amount of $106.36.** 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 receipt of this Order.

Ordered by:

	Michael Bucklin	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.