



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: Travis County Emergency Physicians P.O. Box 2283 Mansfield, TX 76063	MDR Tracking No.: M4-07-0346-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: Hartford Underwriters Insurance Rep Box # 27	Date of Injury:
	Employer's Name: Corde Steele & Associates LLC
	Insurance Carrier's No.: YPUC07287

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "...ER provided w/ 25 modifier..."
 Principle Documentation: 1. DWC 60 package
 2. CMS 1500's
 3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a position summary.
 Principle Documentation: 1. N/A

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)
06/05/06	W4	99284-25-Emergency Dept Visit	1	\$122.20
TOTAL DUE				\$122.20

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. CPT Code 99284 for date of service 06/05/06 denied with "W4- no additional reimbursement allowed after review of appeal/reconsideration. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to State Fee Guidelines", The initial EOB stated that the reimbursement is being withheld as the medical visit is included in the allowance for the surgery or is mutually exclusive to another procedure billed on the same day.

According to 134.202(b) this CPT code is not mutually exclusive to any other procedure which was provided on the same date of service.. Therefore per Rule 134.202(c) (1) reimbursement in the amount of \$122.20 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
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 additional reimbursement in the amount of **\$122.20**. The Division hereby **ORDERS** the insurance carrier 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.

Ordered by:

Authorized Signature

Typed Name

11/29/2006

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.