Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-07-2175-01
SOUTHEAST HEALTH SERVICES PO BOX 453062 GARLAND, TX 75045	DWC Claim #: Injured Employee:
Respondent Name and Box #: LIBERTY INSURANCE CORP REP BOX #: 28	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services): On DOS 05/12/06, "Codes 97140-59 were denied as "global," however, please see the attached documentation marked Exhibit #1 for clarification of these services." On DOS 05/19/06, "Code 93799 was denied as "global," however, please see the attached documentation marked Exhibit #2 for clarification of these services."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Attached clarification letter of Exhibit #1 and Exhibit #2

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "We base our payments on the Texas Fee guidelines and the Texas Workers' Compensation Commission Acts and Rules." "Attached is a copy of the PLN 11 and the documentation from the Medicare Correct Coding Guide to support denial of the disputed services." "It is Liberty Mutual's position that ___ ___shoulder injury does not extend to include her current cardiovascular complaints."

Principle Documentation:

1. Response to DWC 60
2. PLN-11

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
05/12/06	97,U687	97140-59 x 1 DOS ($26.91 x 125%)	1,2,4,5	$32.10<MAR
05/12/06	97,U687	97140-59 x 1 DOS ($26.91 x 125%)	1,2,4,5	$28.10<MAR
05/19/06	W12,X206	93799	1,3	$0.00
Total Due:				$60.20

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, set out the reimbursement guidelines.

Per review of notes, there are no unresolved extent of injury issues. The compensable injury is the shoulder strain.

1. CPT Codes 97140-59 on DOS 05/12/06 were denied by the Respondent with reason code "97" and "U687-This procedure is mutually exclusive to another on this date of service. By clinical standards, this procedure should not or cannot be performed in the same treatment period". CPT Code 93799 for DOS 05/19/06 was denied by the Respondent with reason code "W12" and "X206-The service(s) is for a condition(s) which is not related to the covered work related injury."

2. Per §134.202(b), CPT Code 97140 is a component of CPT Code 98941 billed on the same day. A modifier is allowed in order to differentiate between services; separate payment for the services may be considered justifiable if a modifier is used appropriately. The Requestor billed with modifier -59. The Requestor is seeking below MAR for CPT Code 97140-59; therefore, reimbursement is recommended per §134.202(d)(2).

3. Per §134.202(e)(4), CPT Code 93799 used for heart rate monitoring is an integral component of the Functional Capacity Evaluation 97750-FC performed on same day, therefore no reimbursement is recommended. As regards the extent of injury concerns for cardiovascular complaints, testing for the heart is not an indication that a claim is being made for cardiovascular injury, just a normal procedure within an FCE. It is not reimbursed separately.

4. Per review of Box 32 on CMS-1500, zip code 95217 is located in Dallas County.

5. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge."

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $60.20 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	07/09/07 Date

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.