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 Name and Address: Southeast Health Services P. O. Box 170336 Dallas, TX 75217	MDR Tracking No.: M5-07-3104-01 Claim No.: Injured Employee's Name:
Respondent Name: Travelers Property & Casualty Box 05	Date of Injury: Employer's Name: T Mobile USA Inc. Insurance Carrier's No.: 039CBCEK7743

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Requestor did not submit a Position Statement to MDR.

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Respondent did not submit a Position Statement to MDR.

Principle Documentation:

1. DWC 60 package
2. EOBs

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)
08/30/06	97 & Z014	93799	1	$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 Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. CPT code 93799 billed for date of service 08/30/06 was denied by carrier with denial codes "97" (Payment is included in the allowance for another service/procedure. If reduction, then processed according to the Texas Fee Guidelines.) and "Z014" (Payment is included in the allowance for another service/procedure. This procedure is considered integral to the primary procedure billed). Per Rule 134.202 (C) (iii) a Functional abilities test *includes* submaximal cardiovascular endurance tests, therefore no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 134.1, 134.202

PART VII: DIVISION DECISION

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.

Decision by:

	Eileen V. Atkinson, Medical Dispute Officer	3/01/07
Authorized Signature	Typed Name	Date of Decision

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.