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.: M5-07-3134-01 Claim No.: Injured Employee's Name:
Respondent Name: Travelers Indemnity Company Box 05	Date of Injury: Employer's Name: Fuji Photo Film USA Inc. Insurance Carrier's No.: 039CBCGG8622

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 states in part, "Carrier has not received a corrected bill from provider using modifier 25. Carrier sustains the denial of payment for 99213 and 93799."

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)
04/12/06	97, 97	99213	1	$68.25
05/11/06	97, 97	93799	2	$00.00
06/21/06	97 & 16	93799	3	$00.00
Total Due				$68.25

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 99213 for date of service 04/12/06 was originally denied by carrier with denial code "97" (Pymt is included in the allowance for another service/PX. The service listed under this PX code is included in a more comp code which accurately describes the entire PX(s) performed). The Reconsideration denial was also "97".

CPT code 99213 is not a component to any other service billed on this date of service. Per Rule 134.202, reimbursement is recommended in the amount of **$68.26 ($54.60 X 125% = $68.25)**

2. CPT code 93799 for date of service 05/11/06 was originally denied by carrier with denial code "97" (Payment is included in the allowance for another service/procedure. If reduction then processed according to the Texas Fee Guidelines). The carrier Reconsideration denial was also "97". Per Rule 134.202 (d) (4) (C) (iii) a Functional abilities test *includes a* submaximal cardiovascular endurance tests. This code is included in the FCE, which was billed on the same date of service, therefore, no reimbursement is recommended.

3. CPT code 93799 for date of service 06/21/06 was denied by carrier with denial codes "16"Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remit advice remarks codes whenever appropriate. For payment consideration, provide a description of the service/procedure), and "97" (Payment is included in the allowance for another service/procedure. If reduction then processed according to the Texas Fee Guidelines). Per Rule 134.202 (d) (4) (C) (iii) a Functional abilities test *includes* submaximal cardiovascular endurance tests. This code is included in the FCE, which was billed on the same date of service, 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 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 **$68.25.** 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:

	Eileen V. Atkinson, Medical Dispute Officer	03/12/07
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.