Texas Department of Insurance, Division of Workers' Compensation
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 #: M4-07-3339-01
Southeast Health Services P. O. Box 453062 Garland, TX 75045	DWC Claim #: Injured Employee:
Respondent Name Texas Mutual Insurance Co.	Date of Injury:
Box #: 54	Employer Name: Evergreen Presbyterian Ministry Insurance Carrier #: 99G0000447866

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

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 POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…service has not been proven safe or effective, is not primarily medical in nature and normally used in the absence of illness or injury."

Principle Documentation:

1. Response to DWC 60
2. EOBs

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75212 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
04/17/06	B18, W4, 891, & 893,	E0238-NU	1, 2	$28.73
Total				$28.73

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, sets out the reimbursement guidelines.

On February 8, 2007, the Requestor submitted a withdrawal for CPT codes 76499 & 99211; therefore these codes will not be addressed in this Decision.

1. CPT code E0238-NU billed for date of service 04/17/06 was denied by carrier with denial codes "B18-Payment denied because the procedure code/modifier was invalid on the date of service or claim submission", "W4 – No additional reimbursement allowed after review of appeal/reconsideration", "891 – The insurance company is reducing or denying payment after reconsideration", and "893 – This code is invalid, not covered code or has been deleted from the Texas Fee Schedule".

2. Per the DMERC Region C Fee Schedule, CPT code E0238-NU is a valid HCPCS code for the date of service 04/17/06, therefore, Per Rule 134.202 (c) (2) (A), reimbursement is recommended in the amount of $28.73 ($22.98 X 125% = $28.73).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, 134.201

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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $28.73 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

	Eileen V. Atkinson	5/29/07
Authorized Signature	Medical Fee Dispute Resolution Officer	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.