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: Memorial MRI & Diagnostics 1346 Campbell Road Houston, Texas 77055	MFDR Tracking #: M4-07-4513-01 DWC Claim #: Injured Employee:
Respondent Name: Commerce & Industry Insurance Box #: 19	Date of Injury: Employer Name: Gemstar Construction & Development Insurance Carrier #: 077092491

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "payable through medicare and CCI edit permits payment with use of modifier -51."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Principle Documentation: Response to DWC 60.

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77055 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
11-09-06	97 & 42	36000-51	1, 2 & 5	$29.33
11-09-06	97 & 42	90765-51	1, 3 & 5	$79.16
11-09-06	42 & W1	99144-51	4 & 6	$00.00
11-09-06	97	94760-59	7	$00.00
Total Due:				$108.49

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.

The Requestor withdrew codes J3010-59, J2250-59, J2001-59, A4550-59 and Q9963-59; therefore these services will not be a part of the review by MFDR.

1. This service was denied by the Respondent with reason code "97" (payment is included in the allowance for another service/procedure) and "42" (charges exceed our fee schedule or maximum allowable amount). The Respondent has not made a payment to the Requestor.

2. CPT code 36000 per Rule 134.202(b) is a component procedure of CPT code 90765 also billed for date of service 11-09-06. A modifier in order to differentiate between the services provided is allowed if used appropriately and payment may be considered justifiable. The Requestor billed with an appropriate modifier (51).

3. CPT code 90765 per Rule 134.202(b) is a component procedure of CPT code 99144 also billed for date of service 11-09-06. A modifier in order to differentiate between the services provided is allowed if used appropriately and payment may be considered justifiable. The Requestor billed with an appropriate modifier (51).

4. This service was denied by the Respondent with reason code "42" (charges exceed our fee schedule or maximum allowable amount) and "W1" (Workers Compensation State Fee Schedule Adjustment). The Respondent has not made a payment to the Requestor.

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." Reimbursement is recommended in the amounts of: CPT code 36000-51 = $29.33 and CPT code 90765-51 = $79.16.

6. Per Rule 134.202(b) this service is to be provided by the same physician that performs the diagnostic or therapeutic service that this service supports. The Requestor submitted documentation for review by MFDR which states this service was provided by a different physician than the physician performing the diagnostic or therapeutic service. Based upon the information submitted by the Requestor no reimbursement is recommended.

7. This service was denied by the Respondent with reason code "97" (payment is included in the allowance for another service/procedure). Per Rule 134.202(b) CPT code 97460 is a component procedure of CPT code 99144 also billed for the date of service in dispute. There are no circumstances in which a modifier would be appropriate and the services represent a code combination which is not paid separately. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1 and §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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $108.49 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05-15-07
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.