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: Memorial MRI & Diagnostics 1346 Campbell Road Houston, Texas 77055	MFDR Tracking #: M4-07-5635-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TASB RISK MGMT FUND Box # 47	Date of Injury: Employer Name: Spring Branch ISD Insurance Carrier #: 0250011031803261

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "medicare allowable and not mutually exclusive with the primary procedure code 72131."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "In usual computerized tomography (CT) scanning procedures, a series of transverse or axial images are reproduced (item 1 listed above). These transverse images are routinely translated into coronal and/or sagittal view…Dr. Roman's report (item 4 listed above) for the visit dated December 11, 2006 also states a CT scan will be ordered with no mention of 3-D processing."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01-10-07	97/W4	76377-59	1 - 4	$165.17
Total Due:				$165.17

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.

1. These services were denied by the Respondent with reason codes:
   - 97 - Payment is included in the allowance for another service/procedure. Per Medicare policy guidelines this is included in the benefit for the main procedure.
   - W4 - No additional reimbursement allowed after review of appeal/reconsideration.

2. Per Rule 134.202(b) CPT code 76377 is not global to the other services billed on 01-10-07. The Respondent has denied the service with an inappropriate denial.

3. Per review of Box 32 on CMS-1500 zip code 77055 is located in Harris County.

4. 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." Per Rule 134.202(d)(2) reimbursement is recommended in the amount of $165.17.

A Legal and Compliance referral is made due to the Respondent denying with an inappropriate denial code.

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 $165.17 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

		07/20/07
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.