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's Name and Address:	
M. Lewis Frazier, M.D. 4780 N. Josey Lane Carrollton, TX 75010	MDR Tracking No.: M4-05-1967-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Rep Box # 19	Date of Injury: Employer's Name: Bens Mechanical Inc. Insurance Carrier's No.: 149135613

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states the claim was denied as global.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. CMS-1500
4. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent maintains their position that they appropriately denied reimbursement.

Principle Documentation: 1. TWCC-60 Response

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)
07/16/04	G,F	99213 Office Visit	1	$61.98
TOTAL DUE				$61.98

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003 set out reimbursement guidelines.

1. CPT Code 99213 for date of service 07/16/04 denied with "G" & "F". Per Rule 134.202(b) and CMS CCI Edits (Center For Medicare Services Correct Coding Initiative) this code is not considered global. Therefore per Medicare allowance reimbursement in the amount of $61.98 ($49.58 x 125% = $61.98) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §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 $61.98.**

Ordered by:

Authorized Signature	Typed Name	Date of Order
		05/12/2006

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.