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

	MDR Tracking No.: M4-05-6124-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: SORM Rep Box # 45	Date of Injury:
	Employer's Name: State Of Texas
	Insurance Carrier's No.: 122479

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…Out office respectfully requests your assistance on settling the matter of the denied office visit for the above listed patient. We feel we have met the requirements for the level of service billed…"

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, "…The office will maintain denial of charges as insufficiently documented…"

Principle Documentation: 1. Response to DWC 60

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)
05/24/04	N11,130	99214-Office Visit	1	$00.00
TOTAL DUE				$00.00

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, sets out reimbursement guidelines.

1. CPT Code 99214 for date of service 05/24/04 was denied with "N11-Not appropriate documented, upon review, documentation as submitted does not support the level or service(s) billed", '130-Services unsubstantiated by documentation: Denial after reconsideration". The Respondent did not make a payment. The CPT Code descriptor requirements for CPT 99214 (office visit) requires at least two of these three key components: detailed history, detailed examination, medical decision making of moderate complexity, 25 minutes face to face with the patient. The documentation submitted by the Requestor does not support the level of service billed; there was not a detailed examination or a detailed history. Therefore per Rule 134.202(b) reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
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 not entitled to additional reimbursement.

Decision:

		10/02/2006
Authorized Signature	Typed Name	Date of Decision

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.