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: Dr. Richard Taylor 1920 South Loop 256 Palestine, TX 75801	MDR Tracking No.: M4-05-6198-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Co. Rep., Box #: 19	Date of Injury: Employer's Name: Wal Mart Stores Inc. Insurance Carrier's No.: C1231061

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary from the Table of Disputed Services: "… Claim denied x2 for documentation does not support. Submitted with all supporting documentation that shows that we met the requirements for the level of service billed on each date of service."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "… no further payment was recommended towards the amount in dispute. Please refer to the attached re-evaluations and explanation of benefits reports…"

Principle Documentation: 1. Position Summary
2. EOBs

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)
7-29-04 – 9-27-04	N/O	99214 x 2 DOS	1	$193.82
TOTAL DUE				$193.82

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.

The Respondent's EOB denial codes for CPT codes 99214 asserted, "N - Not documented" and "O – Denial After Reconsideration". The Respondent also stated "The medical records submitted do not support code 99214. The documentation for 99214 must contain at least two of the following components: a detailed history; a detailed examination; medical decision making of moderate complexity. At this time, no allowance is recommended."

1. The Requestor provided medical reports for an established patient office visit for both disputed dates of service. In reviewing both reports, the Requestor has met two of the CPT code description requirements. Therefore, reimbursement is recommended in the amount of $193.82 ($77.53 x 2 DOS x 125% MAR) for the office visits on 7-29-04 and 9-27-04.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d) and §413.031
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.1

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 $193.82 plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

	Roy Lewis	8-21-06
Authorized Signature	Typed Name	Date of Order

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.